Materials Relating to
Vanderbilt University Medical Center

EXHIBIT 1

EXHIBIT 1-A

Social media posts spark calls to investigate Tenn.'s VUMC

By KIMBERLEE KRUESI September 21, 2022

RELATED TOPICS

Health
Social media
Tennessee
Nashville
Gay rights
Vanderbilt University

NASHVILLE, Tenn. (AP) — Tennessee Gov. Bill Lee has called for an investigation into a pediatric transgender health clinic after videos surfaced on social media of a doctor touting that gender-affirming procedures are "huge money makers" for hospitals and a staffer saying anyone with a religious objection should quit.

Vanderbilt University Medical Center came under fierce scrutiny Tuesday after conservative political commentator Matt Walsh posted a series of tweets accusing the private hospital of opening its transgender health clinic because it was profitable, as well as criticizing some of the treatments VUMC provides to minors.

The posts included a video of one VUMC doctor in 2018 saying these "types of surgeries bring in a lot of money" and later saying that female-to-male bottom surgeries are "huge money makers." A separate video shows another staffer warning that if employees do not want to participate in transgender treatments then they "probably shouldn't work at Vanderbilt," and warned that objections should be met with "consequences."

"We should not allow permanent, life-altering decisions that hurt children or policies that suppress religious liberties, all for the purpose of financial gain," Lee, a Republican running for reelection this year, said in a late Tuesday statement. "We have to protect Tennessee children, and this warrants a thorough investigation."

HOMELESSNESS

Attorneys for Jordan Neely's family call for murder charges

Georgia lawmakers: Localities must apply homeless camp bans

Oregon lawmakers approve $200M for housing, homelessness

Georgia House seeks more improvements to mental health

The governor did not specify what laws the Nashville-based hospital may have violated, but his spokesperson told The Associated Press that they had passed along concerns to Attorney General Jonathan Skrmetti.

Skrmetti's office did not rule out an investigation when reached by the AP on Wednesday.

"We are aware of allegations of illegal conduct at the Clinic for Transgender Health at Vanderbilt University Medical Center," said spokesperson Samantha Fisher in an email. "General Skrmetti will use the full scope of his authority to ensure compliance with Tennessee law."

Fisher did not immediately respond to questions seeking clarity on what law specifically VUMC may have violated.

In a statement, VUMC said it started its transgender health clinic in 2018 because transgender people face higher risks for mental and physical health issues.

"VUMC requires parental consent to treat a minor patient who is to be seen for issues related to transgender care and never refuses parental involvement in the care of transgender youth who are under age 18," said spokesperson Craig Boerner in a statement.

Boerner added that VUMC employees are allowed to decline to participate in any treatment they find morally objectionable and prohibits discrimination against employees who do so.

"We have been and will continue to be committed to providing family-centered care to all adolescents in compliance with state law and in line with professional practice standards and guidance established by medical specialty societies," he said.

Boerner declined to answer any additional questions, including how many treatments the clinic has provided to minors and what types. The websites for VUMC's transgender health clinic and LGBTQ health programs were down Wednesday.

The social media posts have attracted the attention of key Tennessee Republican lawmakers — many of whom are also running for reelection — vowing to further limit gender-affirming treatments when the General Assembly reconvenes in January. Meanwhile, Tennessee's U.S. Sen. Marsha Blackburn praised Gov. Lee's call for an investigation.

Nationally, Republicans have increasingly pushed to restrict LGBTQ rights in their effort to drive the party's base and push the bounds in already GOP-strongholds.

Tennessee over the years has been on the front lines among Republican-dominated statehouses advancing anti-LGBTQ legislation. Just last year, Republican lawmakers and Gov. Lee banned doctors from providing gender-confirming hormone treatment to prepubescent minors even though advocates maintain that no doctor in Tennessee was doing so.

Lee also approved banning transgender athletes from playing girls' public high school sports or middle school sports after declaring that allowing transgender girls to participate would "destroy women's sports."

Such transgender-focused legislation is commonly challenged in court. While Tennessee's youth transgender ban remains in effect, Arkansas is currently blocked from enforcing a similar version. A federal judge in May blocked a similar law in Alabama.

In Texas, child welfare officials have been blocked from investigating three families of transgender youth over gender-confirming care the minors have received.

EXHIBIT 1-B

(Conventionally Filed)

EXHIBIT 1-C

PATH to Affirmative Medical Care for Transgender/Gender Diverse (TGD) Youth

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OBJECTIVES

- Review terminology and language commonly used by patients who identify as gender diverse
- Define options for affirmative care that are available to gender diverse youth who are considering or seeking a medical affirmation
- Describe ethical concerns and offer recommendations for healthcare providers who are caring for a gender diverse population

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VANDERBILT PEDIATRIC & ADOLESCENT TRANSGENDER HEALTH (VPATH)

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DEFINITIONS

- **Natal sex** - sex assigned at birth, typically based on genitalia
- **Gender identity** - sense of male/female/both/neither
- **Gender expression** – presentation of identity such as through appearance, dress, or behavior
- **Sexual orientation** - direction of an individual's sexuality, classifiable according to the sex or gender of the persons whom the individual finds sexually attractive

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DEFINITIONS

- **Gender dysphoria** - distress with natal sex assignment and gender identity
- **Transgender** - adjective to describe individuals whose gender identity and sex assigned at birth do not correspond
- **Gender nonconformity** - variation from cultural norm in gender expression
- **Gender nonbinary** - assigned either sex at birth and identify as neither, both, or fluid gender

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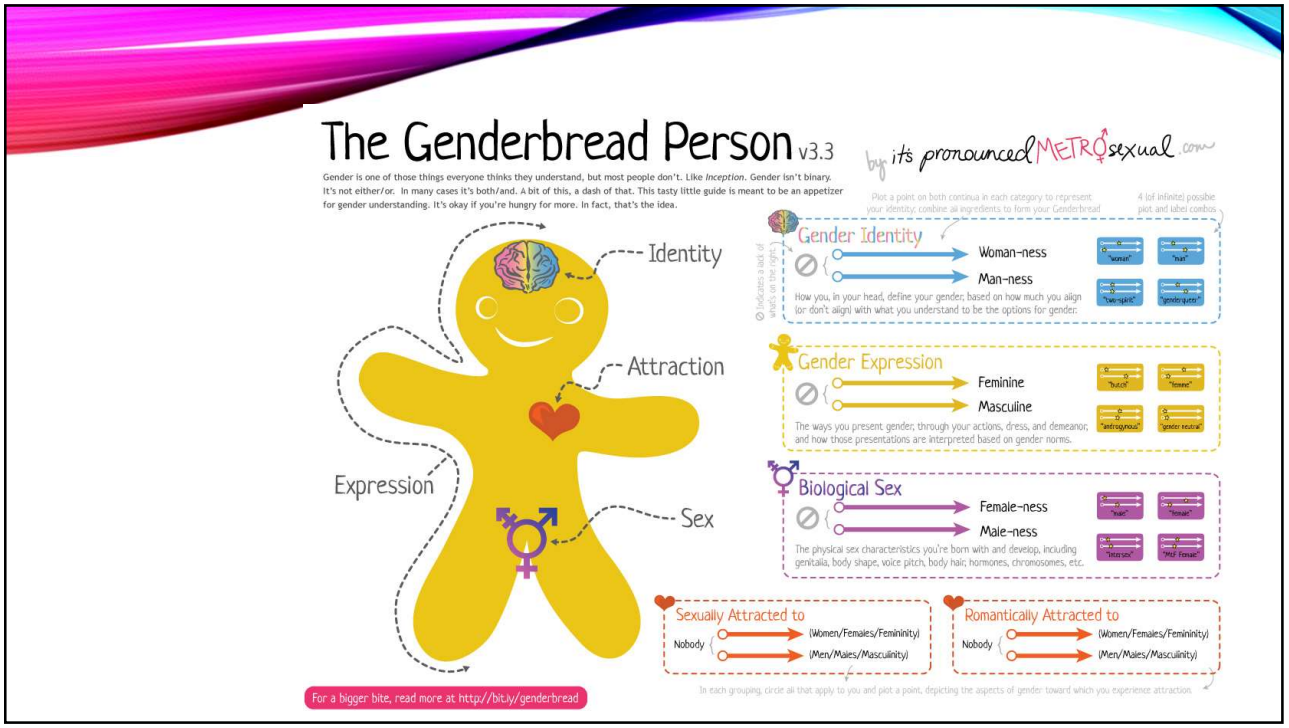

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NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Learning Resources | What We Offer | About Us | My Learning

LGBTQIA+ Glossary of Terms for Health Care Teams

Publication Originally published on 3 February, 2020

Becoming familiar with terms used by lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender minorities (LGBTQIA+) can help you provide patients with the highest quality care. In this glossary, you will find terms relevant to the health care and identities of LGBTQIA+ people.

Download this Publication

Filed under Introduction to LGBTQIA+ Health

https://www.lgbtqiahealtheducation.org/publication/lgbtqia-glossary-of-terms-for-health-care-teams/

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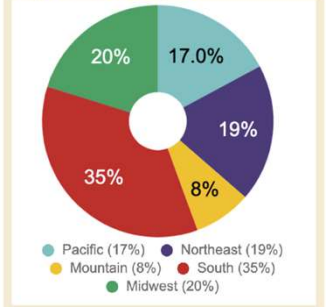
PREVALENCE

Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples

Esther L. Meerwijk, PhD, and Jae M. Sevelius, PhD

- Ability to estimate incidence and prevalence is limited
- 390 per 100,000 adults (about 1:250 adults)
- Rates as high as 0.6% of population
- AMAB: 1 : 7,000 – 1 : 20,000
- AFAB: 1 : 33,000 – 1 : 50,000
  - more recently this is being reversed
  - may differ pre/post puberty

Fig. a: Distribution of adults in the United States who are LGBTQ segmented by region[18]



(Harless et al., 2019; McNamara et al., 2016)

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- Gen Z (1997 – 2012)
  - **1 in 6** (15.9%) said they are queer or transgender
  - 50% believe traditional gender norms outdated
  - 1 in 3 open to dating different genders
  - 1 in 5 open to polyamory
- Millennials (1981- 1997)
  - **1 in 10** said they are LGBTQ+ with a high percentage (8.1%) declining to answer
- In 2012, just 3.5% of American adults said they were LGBTQ+

them.

(Clifton, 2021; Lang, 2021; Sonoma, 2020)

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GENDER DIVERSE (TGD) YOUTH

(de Vries et al., 2010; Drummond et al., 2008; Littman, 2018; Strang et al., 2018; Wallien & Cohen-Kettenis, 2008)

- Timing can be variable
  - May present early in childhood or with onset of puberty
  - Late onset may surprise parents
- Fluidity in prepubertal children vs. adolescents
  - Children persist 12-27%
  - Adolescents near 100% persistence
- Gender ratio 3:1 AMAB/AFAB in children; 1:1 in adolescents
- Commonly comorbid with other conditions, such as ASD

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GENDER DEVELOPMENT

- Across lifespan
  - 2 – 3 yo: basic gender identity
  - 3 – 5 yo: gender stability
  - 5 – 7 yo: gender consistency
  - 10 yo+: identity, expression, role continue to develop and flex over time
- Influenced by nature and nurture
  - Early experiences
  - Social learning
  - Biology

(Ron-Li Liaw & Janssen, 2014)

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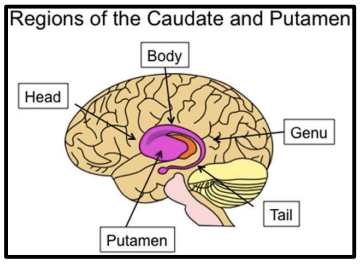
BIOLOGY OF GENDER IDENTITY

- Pre and postnatal exposure to androgens
  - Data is from DSD population
- Gender dysphoria as high as 39% in monozygotic twin pairs (Heylens et al., 2012)
  - Several studies suggest this but date back to early 2000s
- Brain studies



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MENTAL HEALTH CONCERNS

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TGD MENTAL HEALTH RISKS

Higher risk than sexually diverse (LGB) peers for experiencing negative health outcomes, substance use, trauma victimization, homelessness, stigma, and/or minority stress.

- 53% of TGD youth felt sad or hopeless
- 43.9% considered suicide vs. 11 - 20.3% of cisgender peers
- 34.6% of transgender students attempted suicide vs. 5.5 – 9.1% cisgender peers

(Cohen et al., 2018; Johns et al., 2019; National Resource Center for Mental Health Promotion and Youth Violence Prevention, n.d.)

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DSM-5

GENDER DYSPHORIA

"A marked incongruence between one's experienced/expressed gender and assigned gender, of **at least 6 months duration**. . .

The condition is associated with clinically significant **distress or impairment** in social, school, or other important areas of functioning"

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ROLES OF MENTAL HEALTH PROVIDER

- Directly **assess gender dysphoria**
- Provide **supportive psychotherapy** and **family counseling**
  - Explore identity
  - Enhance self-esteem and body image
  - Alleviate dysphoria and other psychosocial difficulties
  - Address stigma and internalized transphobia
  - Promote resilience
- Assess and treat **co-existing mental health concerns**
- Refer for **medical intervention** as appropriate
  - Provide psychoeducation and support decision making
- Educate and **advocate** (Cyperski, Romano, & Brady, 2020)
- Enhance social and peer **support**
  - Provide information and referrals, such as support groups

(WPATH, 2011)

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AFFIRMATIVE CARE FOR CHILDREN & ADOLESCENTS

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CREATING A WELCOME ENVIRONMENT FOR LGBTQ+ PATIENTS

WHAT TO DO

- Establish **gender-neutral bathrooms** and avoid restroom signage that specifically designates one gender or another*
- Avoid **clinic names and signs** that seem welcoming to only one gender (e.g., Men's Health Center)
- Create initial patient intake forms that **collect information** on the patient's name, pronouns, gender identity, sex assigned at birth, partner(s) and other family members
- Create electronic **health record/forms** that allow for collection of gender identity and natal sex that also include an anatomic inventory

WHY

- Transgender individuals should feel comfortable, safe using a restroom that corresponds to their gender identity and expression
- Gender-specific clinic names or centers may not affirm or appeal to gender diverse people
- This information will help providers and staff address the patient correctly, by name and pronoun
- Help providers address individuals' specific healthcare needs according to their natal sex and current anatomy

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INITIAL HEALTHCARE ENCOUNTER

- Ask open ended questions about identity for all
- Defer to your patient on language, name, pronouns
- Be aware of confidentiality issues—particularly as they pertain to adolescents
- Assess for safety at home, in school
- Review risk-taking behaviors (e.g., sexual activity, substance use)
- Assess mood (e.g., depression, self-harm behaviors, suicide)
- Keep open mind and don't make assumptions about individual path to affirmation

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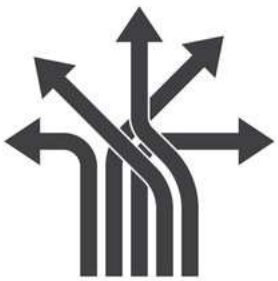
OPTIONS FOR AFFIRMATION

- Goal: to help people feel more confident and comfortable
- Individualized approach to alleviating GD
  - Psychotherapy
  - Peer support (e.g., GSA)
  - Parental resources (e.g., PFLAG)
  - Social transition (e.g., school, legal name)
  - Resources for affirmative clothing (e.g., binders, gaff, swimwear)
  - Gender affirming hormones (i.e., pubertal blockers and/or hormone therapy)
  - Surgery



(WPATH, 2011)

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REAL-LIFE EXPERIENCE (RLE)

- "The act of fully adopting a new or evolving gender role or gender presentation in everyday life"
- Previous guidelines recommended living **12 months** full-time in the desired gender role prior to medical intervention
  - Consider the person and individual needs (e.g., may be challenging to transition as a "female with a beard")

(Hembree et al., 2017)

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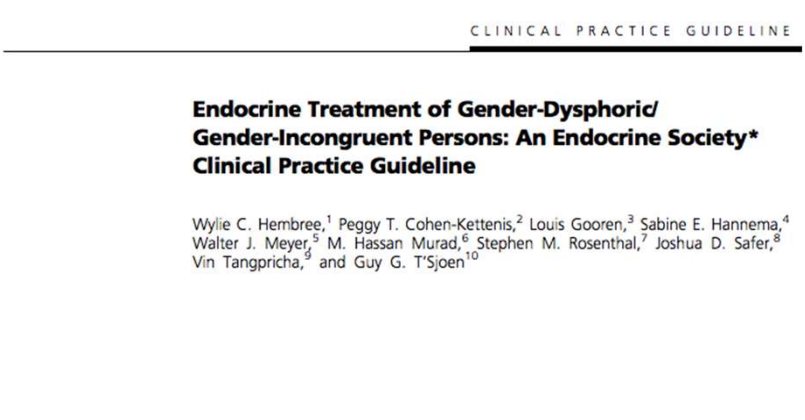
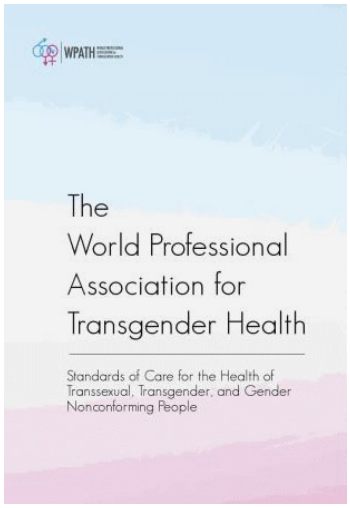
BEST PRACTICE GUIDELINES



CLINICAL PRACTICE GUIDELINE

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen[10]



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CASE EXAMPLE

Ryan (12)

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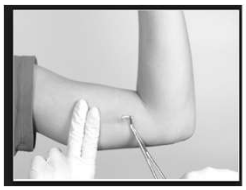
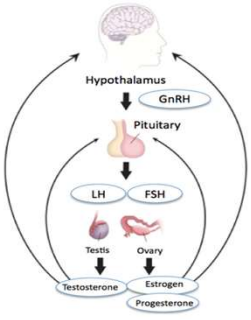
"PUBERTAL BLOCKERS"

- GnRH agonists
  - Leuprolide (Lupron), Supprelin (Histrelin/Vantas)
  - Fully reversible
  - Tanner stage 2/3
  - Significant increase GD with puberty
  - Effects on bone?
  - Fertility
  - Expense
    - ~$1500/month Lupron
    - ~$15,000 for Histrelin





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ALTERNATE BLOCKING AGENTS

- Medroxyprogesterone acetate PO or IM (MTF or FTM)
  - Inhibits the HPG axis and inhibits gonadal steroidogenesis
  - Menstrual suppression
- Spironolactone PO (MTF)
  - Inhibits T synthesis and action
- Finasteride PO (MTF)
  - Inhibits 5 a-reductase, blocking conversion of T to DHT

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GENDER AFFIRMING HORMONES

- Previously recommended start at age 16, but consider as early as 14 yo
- Continue pubertal blockers
- Fertility preservation and consent prior to initiation

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RESULTS

Masculinizing

- Cessation of menses
- Increased libido
- Increased facial and body hair
- Increased oiliness to skin
- Increased muscle/redistribution of fat mass
- Deeper voice

Feminizing

- Decreased libido
- Decreased facial and body hair
- Decreased oiliness of skin
- Breast tissue growth
- Redistribution of fat mass

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ESTRADIOL RISKS

Likely increased risk

- Venous thromboembolic disease (blood clot or stroke)
- Gallstones
- Elevated liver enzymes
- Weight gain
- Elevated triglycerides
- Severe migraine headaches
- Cardiovascular disease

Possible increased risk

- High blood pressure
- Elevated prolactin level or benign brain tumor (prolactinoma)
- Infertility
- Type 2 Diabetes

No increased risk or inconclusive risk

- Breast cancer

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TESTOSTERONE RISKS

Likely increased risk

- Polycythemia (increased number of red blood cells)
- Weight gain
- Acne
- Male pattern balding
- Sleep apnea

Possible increased risk

- Elevated liver enzymes
- Hyperlipidemia (elevated cholesterol)
- Thromboembolism
- Infertility
- Worsening of certain psychiatric problems
- Cardiovascular disease
- Hypertension
- Type 2 Diabetes

No increased risk or inconclusive risk

- Loss of bone density
- Breast cancer
- Cervical cancer
- Ovarian cancer
- Uterine cancer

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SURGERY

VANDERBILT UNIVERSITY MEDICAL CENTER

For minors:

- Top surgery
  - Hormone therapy for 12 mo+
  - Completed chest development
  - Support of both parents
  - Followed and cleared by MHP
- Bottom surgery not available

For adults:

- Top surgery
  - Hormone therapy recommended for 6 mo+
  - Letter from MHP
- Bottom surgery
  - Hormone therapy for 12 mo+
  - Two letters of recommendation
    - Community MHP
    - Evaluation at VUMC

Note: May vary by MCO

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CASE EXAMPLE

Dylan (16)

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NEXT STEPS TO SUPPORT YOUTH

Even if youth is not a candidate for GAH at this time, we can still…

- Reduce dysphoria and **manage distress** or uncertainty
- Treat co-occurring **psychiatric symptoms**
- Give room to **explore** different options for gender expression
  - Normalize change and fluidity in exploration, especially for children
- Help family have an **accepting and nurturing** response to their child
  - Answer questions, address concerns
  - Support pronoun use
  - Support decision making re: extent to which youth can safely express identity
- Support youth in developing **positive self-concept**
- Strive to remain available and maintain **therapeutic relationship** throughout social changes and/or physical interventions
- Collaborate and **advocate**

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ADDITIONAL CONSIDERATIONS

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ETHICAL CONSIDERATIONS

- Confidentiality and consent
  - Coming out
  - Diagnosis
  - Documentation
- Gatekeeping (Budge, 2015)
  - Discriminatory
  - Impact on working alliance and engagement
- Risk of withholding letter of support and/or affirmative care
  - Prolong gender dysphoria
  - Suicidal ideation and attempt
  - Contribute to appearance that may elicit abuse or stigmatization
  - Health and safety (e.g., black market; binding)

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FAMILY ENGAGEMENT

LGBT young people who are **HIGHLY REJECTED** by their parents…

3x more likely to use **illegal drugs**
3x more likely to be at high risk for **HIV and STIs**
6x more likely to report high levels of **depression**
8x more likely to attempt **suicide**

…compared to those who are only **SLIGHTLY REJECTED** by family.

(Ryan, 2009)

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USE CORRECT PRONOUNS AND CHOSEN NAME.

An increase of one context (e.g., home, school, friends) where children are able to use their chosen name is associated with 5 unit decrease in depressive symptoms, 29% decrease in suicidal ideation, and 56% decrease in suicidal behavior.

(Russell et al., 2018)

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CLOSING

- Provide a safe and affirming space for patients to share their gender identity
- Be aware of various options for treating gender dysphoria
- Understand best practices in assessment and treatment of youth
  - Affirming and supportive
  - Comprehensive assessment
  - Suicide risk and frequent screening
  - Family, family, family
- Collaboration with patient and caregivers
- Consultation with colleagues, experts

(GLSEN)

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RESOURCES

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EXHIBIT 1-D

(Conventionally Filed)

EXHIBIT 1-E

(Conventionally Filed)

EXHIBIT 1-F

A Primer for Transgender Health

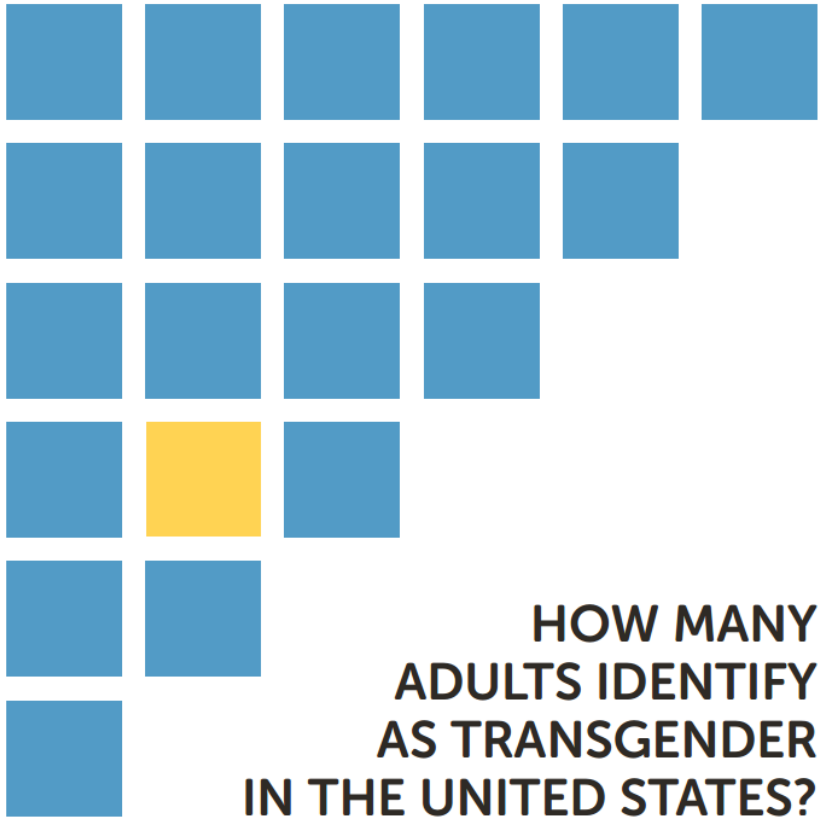
Southeast/TN AIDS Education and Training Center

Shayne Sebold Taylor, MD
Assistant Professor
Departments of Internal Medicine and Pediatrics
1.30.2019

Disclosures

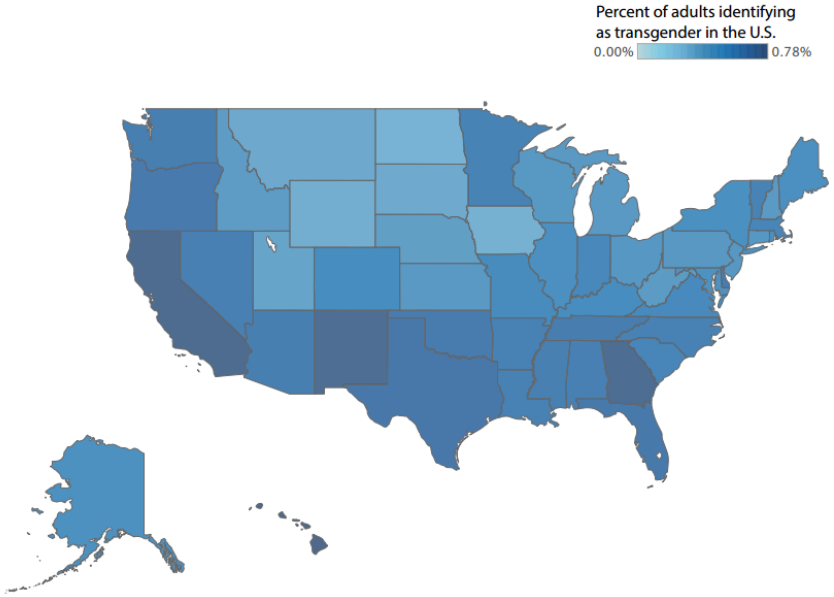
- Unfortunately, no financial disclosures.
- I am a cis-gender, white, heterosexual female from an upper middle class background.

Number of Adults Who Identify as Transgender



~0.6% of adults – 1.4 million Americans – identify as transgender

Figure 1. Percent of Adults Who Identify as Transgender in the United States



http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

Algorithm Construction

At least 1 ICD9 Code:

- 302.50 - "Trans-sexualism with unspecified sexual history"
- 302.51 - "Trans-sexualism with asexual history"
- 302.52 - "Trans-sexualism with homosexual history"
- 302.53 - "Trans-sexualism with heterosexual history"
- 302.6 - "Gender identity disorder in children"
- 302.85 - "Gender identity disorder in adolescents or adults"

At least 1 Keyword:

- Gender dysphoria
- Genderqueer
- MTF
- FTM
- Transgender
- Transsexual
- Trans
- Cross-dress
- Tranny

Table 1: Demographics of VUMC Transgender Cohort

	N	Percent
Race		
White	162	70%
Black	39	17%
Other	13	6%
Unknown	41	18%
Gender Identity		
MTF	23	10%
FTM	18	8%
Gender non-binary	0	0%
Transgender Unspecified	191	82%
Sex Changed in EMR		
Yes	43	19%

Beach, L & Ehrenfeld, J et al. "Development of a natural language processing algorithm to identify transgender patients in the Vanderbilt University Medical Center electronic health records system," 2016.

A Growing Population

- According to Williams Institute Survey, approximately 262,000 adults identify as transgender in the Southeast (TN, AL, MS, LA, FL, KY, GA)
- By the year 2020, estimated 1,077 transgender individuals in the Vanderbilt system[2]

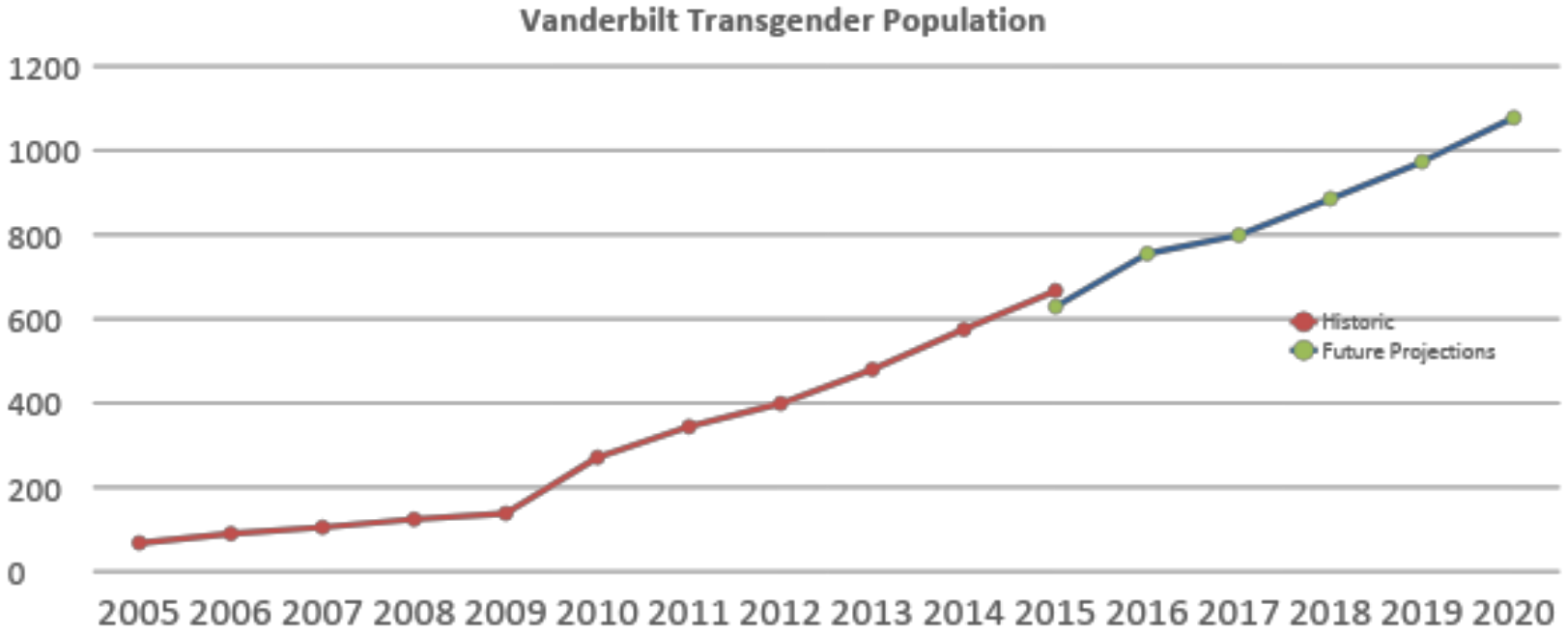


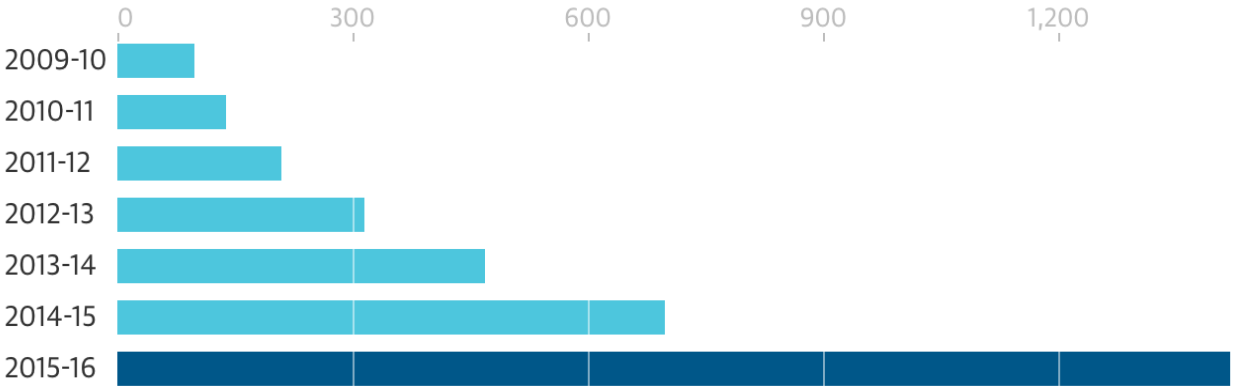
Figure Courtesy of Lea Davis, PhD 2016.

[2]Data derived from VUMC Synthetic Derivative, number of new individuals with ICD codes/keywords added to EHR within the last year, linear extrapolation over the next 5 years.

Leads to an (Exponentially) Growing Need

Pediatric Gender Clinic

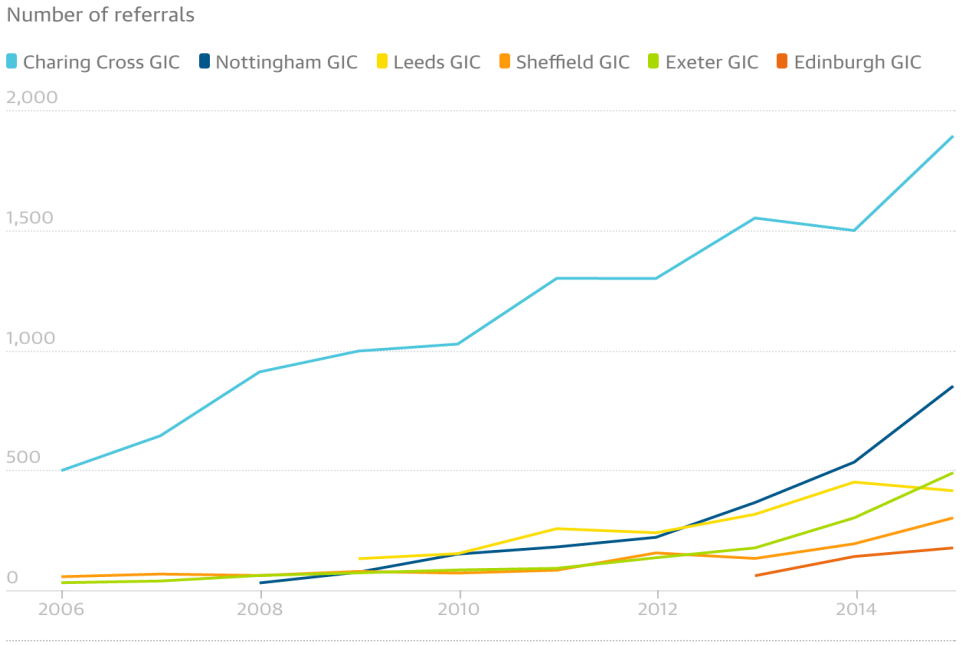
Referrals of children and adolescents to the Tavistock clinic for gender dysphoria **doubled in the last year**



Guardian graphic | Source: Tavistock and Portman NHS Foundation Trust

Adult Gender Clinic

Referrals to adult gender identity clinics across the UK **have increased dramatically over the past 10 years**



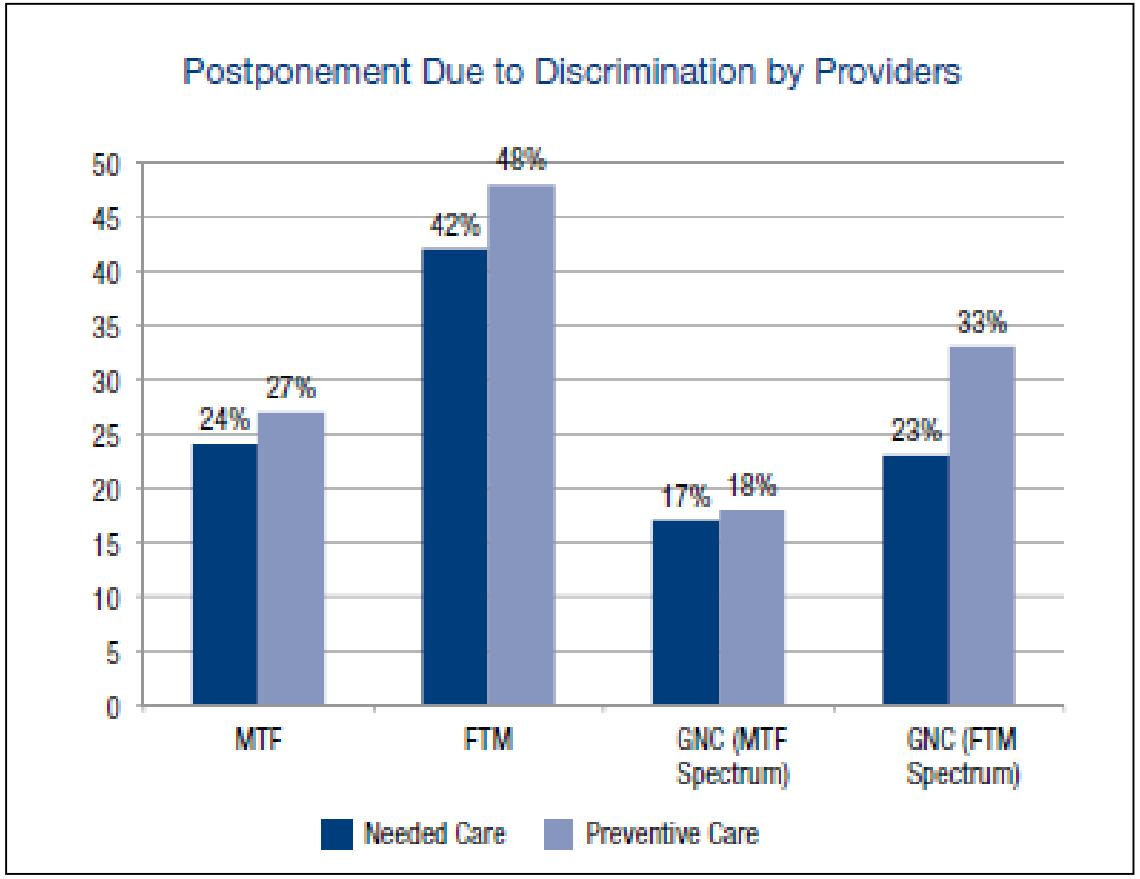
Note: calendar year figures used except for Charing Cross GIC, Exeter GIC and Leeds GIC which use a fiscal year

Lyons, K. The Guardian, Travistock and Portman NHS Foundation, 2016.

Health Concerns for Transgender People

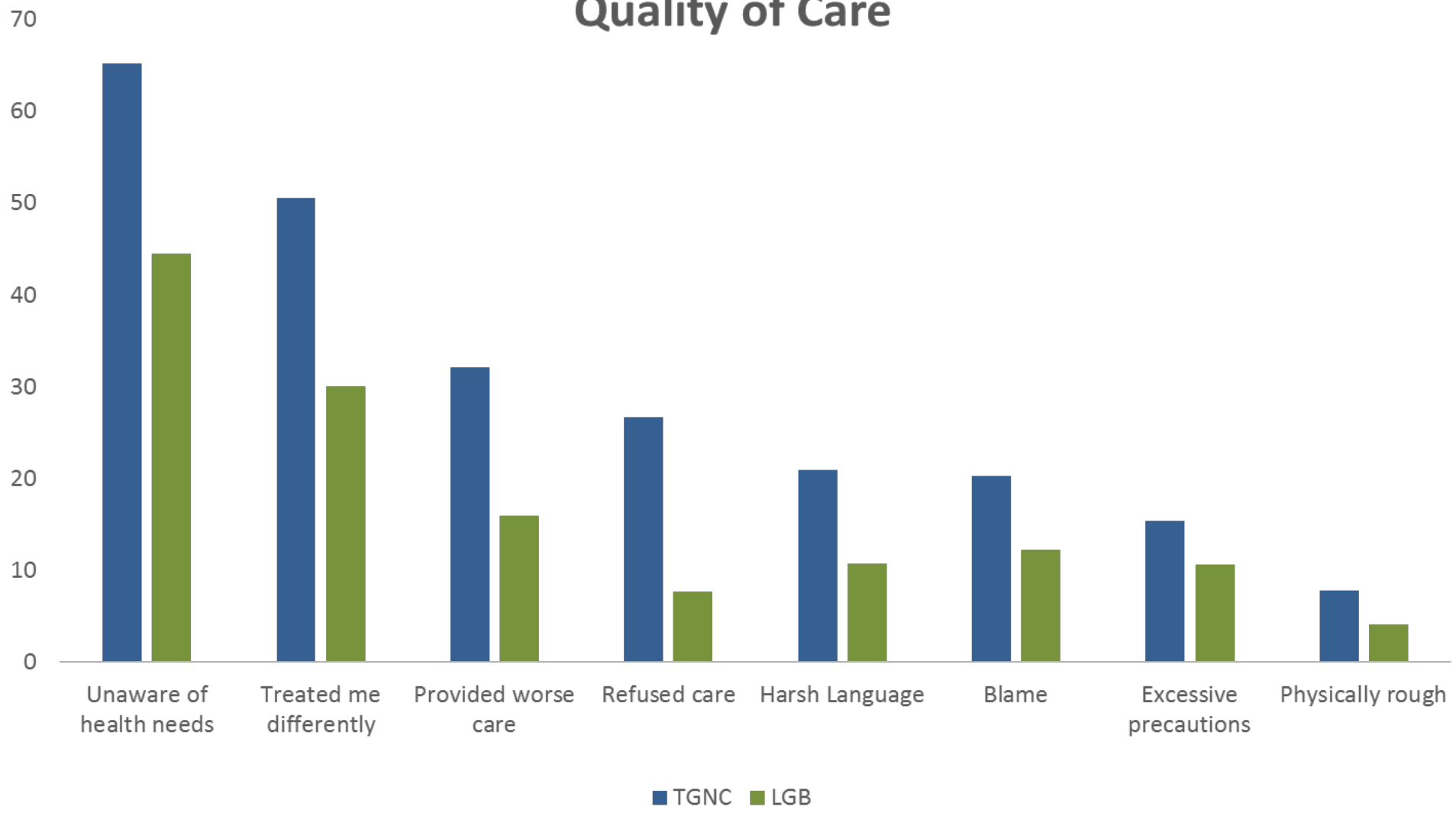
Transgender communities:

- are currently underserved
- are more likely to delay care due to fear of discrimination or past negative experiences
- face challenges in finding friendly and knowledgeable providers
- higher rates of depression, anxiety, and suicide
- higher incidence of HIV/AIDs



Grant et al., 2011.

Health Care Access: Quality of Care



Source: Lambda Legal "When Health Care Isn't Caring" study, 2010

HEALTH DISPARITIES AMONG TRANSGENDER PEOPLE

- One in four (25%) respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.

- More than half (55%) of those who sought coverage for transition-related surgery in the past year were denied, and 25% of those who sought coverage for hormones in the past year were denied.

Source: The 2015 U.S. Transgender Survey

HEALTH DISPARITIES AMONG TRANSGENDER PEOPLE

- One-third (33%) of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender, with higher rates for people of color and people with disabilities. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.

- In the past year, 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 33% did not see a doctor when needed because they could not afford it.

Source: The 2015 U.S. Transgender Survey

Caring for the Transgender Patient

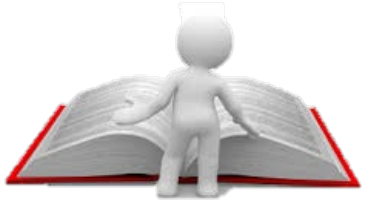
A quick review of terms and nomenclature

What do these terms mean to You?

Sex

Gender

Sexual Orientation



Sex

A medically assigned identity based on physical packaging – our chromosomes, hormones, and genitalia.

female, male, intersex

Gender Identity

Our inner sense of being a man, woman, or another gender; "how the mind and the heart regard the body."

woman, man, trans woman, trans man, nonbinary

Gender Expression

The ways in which we externally communicate our gender identity to others, such as through mannerisms, clothing, body language, roles, hairstyles, etc.

feminine, masculine, androgynous, butch, femme

Sexual Orientation

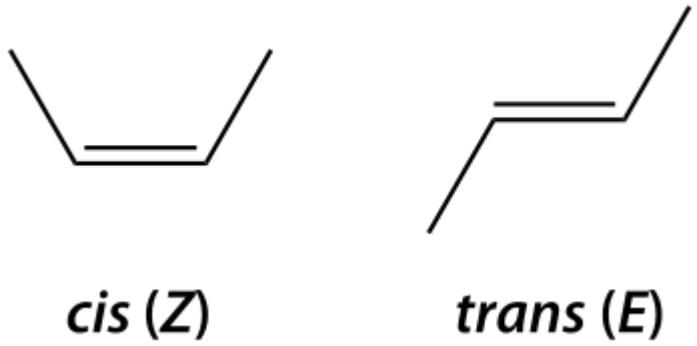
An enduring emotional, romantic, sexual, affectional, & relational attraction to other people.

Determined by the personally significant sexual or romantic attractions one has, and the way in which someone self-identifies.

lesbian, gay, bisexual, MSM, WSW, queer, asexual, pansexual, straight

“Definitions”

- Transgender
  - Describes people whose gender identity differs from their sex assigned at birth
- Cisgender
  - A person who is not transgender



cis (*Z*) *trans* (*E*)

“Definitions” Continued

Transgender people are very diverse and use many different terms to describe themselves. These terms tend to change over time. Some of the more common terms in 2018 include:

- Transgender woman, trans woman, male-to-female (MTF)
  - A person assigned male at birth who identifies as a woman
- Transgender man, trans man, female-to-male (FTM)
  - A person assigned female at birth who identifies as a man

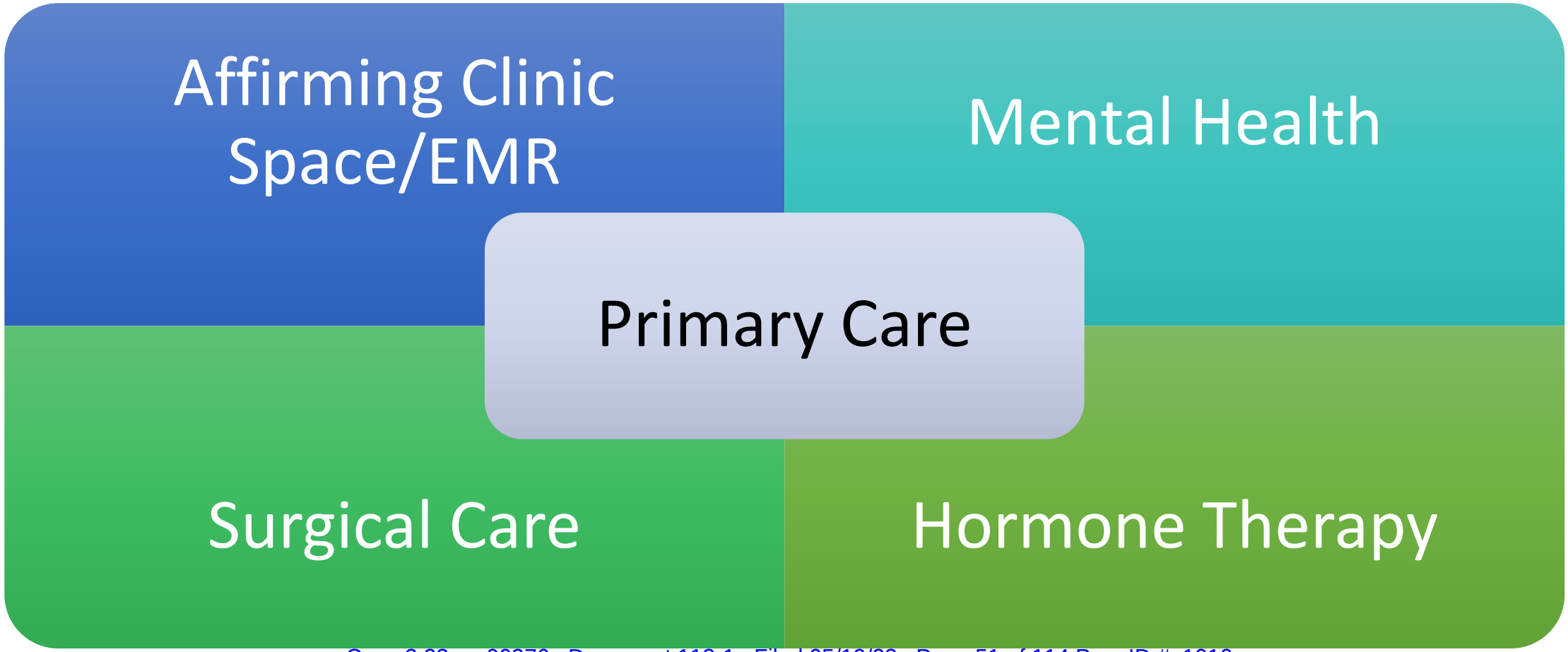
Gender identity ≠ sexual orientation

- Sexual orientation
  - How a person identifies their physical and emotional attraction to others
  - Dimensions include: desire/attraction, behavior, and identity
- All people have a sexual orientation and a gender identity

- Transgender people can be any sexual orientation

- James S.E. HJL, Rankin, S., Keisling, M., Mottet, L., & Anafil, M.: **The Report of the 2015 U.S. Transgender Survey**. In. Washington, D.C.: National Center for Transgender Equality; 2016.

Shayne Taylor's 5 pronged approach to caring for Transgender Patients



Primary Care: Screen the parts they have. Assign no value or meaning to these parts.

Primary Care Case Example

- 40yo male to female transgender patient here to establish care. Has been on hormone therapy (spironolactone and estradiol) for the last 10 years prescribed by an endocrinologist in town who has just retired. Hopeful to have you take over hormone therapy. Has had top surgery (breast augmentation, 2003), but has not had any bottom surgery. Not currently sexually active, but interested in men. Other medical problems include HTN, treated with lisinopril.

What parts does this patient have?

- Breasts, prostate, testes, penis
- Assign no value or meaning to these parts.
- Your goal is just to keep them healthy

Screen according to Parts and Practices

- Screen according to the parts (and sexual practices)!
  - No good research on mammography in MTF trans patients, UCSF recs mammograms in patients >50 who have been on HRT >5 years
  - Prostate Cancer (and cervical cancer screen per guidelines)
    - Interpretation within the right context (PSA values may be off on hormone therapy, cervical atrophy on testosterone therapy)
  - Depression/anxiety/substance use/tobacco use
  - Suicidality
- Vaccines per ACIP guidelines, HepA/HepB if engages in sex with men

Mental Health Case Presentation

- 65yo male to female transgender veteran here to establish care. Served in Vietnam and has PTSD. Smokes 1ppd, has uncontrolled DM (last A1c 11%), history of CVA with residual right sided weakness, and CAD s/p NSTEMI. Came out as transgender 5 years ago. Has not yet found a doctor willing to do hormone therapy given her medical history. Came out to wife who is entirely unsupportive. Can't divorce her due to her veteran benefits. They live in separate parts of the house, and go weeks without talking. Kids don't want her around their children.

Specific Mental Health Concerns

Mental Health Concerns

- Suicide
- Mood Disorders
- Anxiety Disorders
- PTSD
- Body Image / Eating Disorders
- Substance Use Disorders
- Personality Disorders

Suicide

- Rates of suicide attempts among gender and sexuality minorities ranging from **1.5-7x** rate of heterosexual, cis-gendered peers
- Transgender adults suffer the greatest suicide risk
  - Sparse data available; estimates range between 10%-45% of transgender and gender variant individuals attempt suicide

- *Haas A, al. e. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. Journal of Homosexuality. 2011; 58: p. 10-51.*
- *King M, al. e. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. BMC Psychiatry. 2008; 8(70).*

Mood Disorders

- Elevated depression risk in transgender pts (44.1%)
- Social stigma was positively associated with psychological distress, but is moderated by peer support from other transgender people
- Strong evidence that **depression symptoms improve dramatically** with the initiation of **gender affirmation treatments**, including hormones

- *Gorin-Lazard A, et al. Hormonal therapy is associated with better self-esteem, mood, and quality of life in transsexuals. Journal of Nervous and Mental Disorders. 2013; 201: p. 996-1000.*
- *Bockting W, Miner M, Swinburne Romine R, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J. of Public Health. 2013 May; 103(5): p. 943-951.*
- *Hoffmann B. An overview of depression among transgender women. Depression Research & Treatment. 2014: p. 1-9.*

Gender Affirming Care

What are your transition goals, and how can I help you get there?

Treatment Considerations: Female to Male

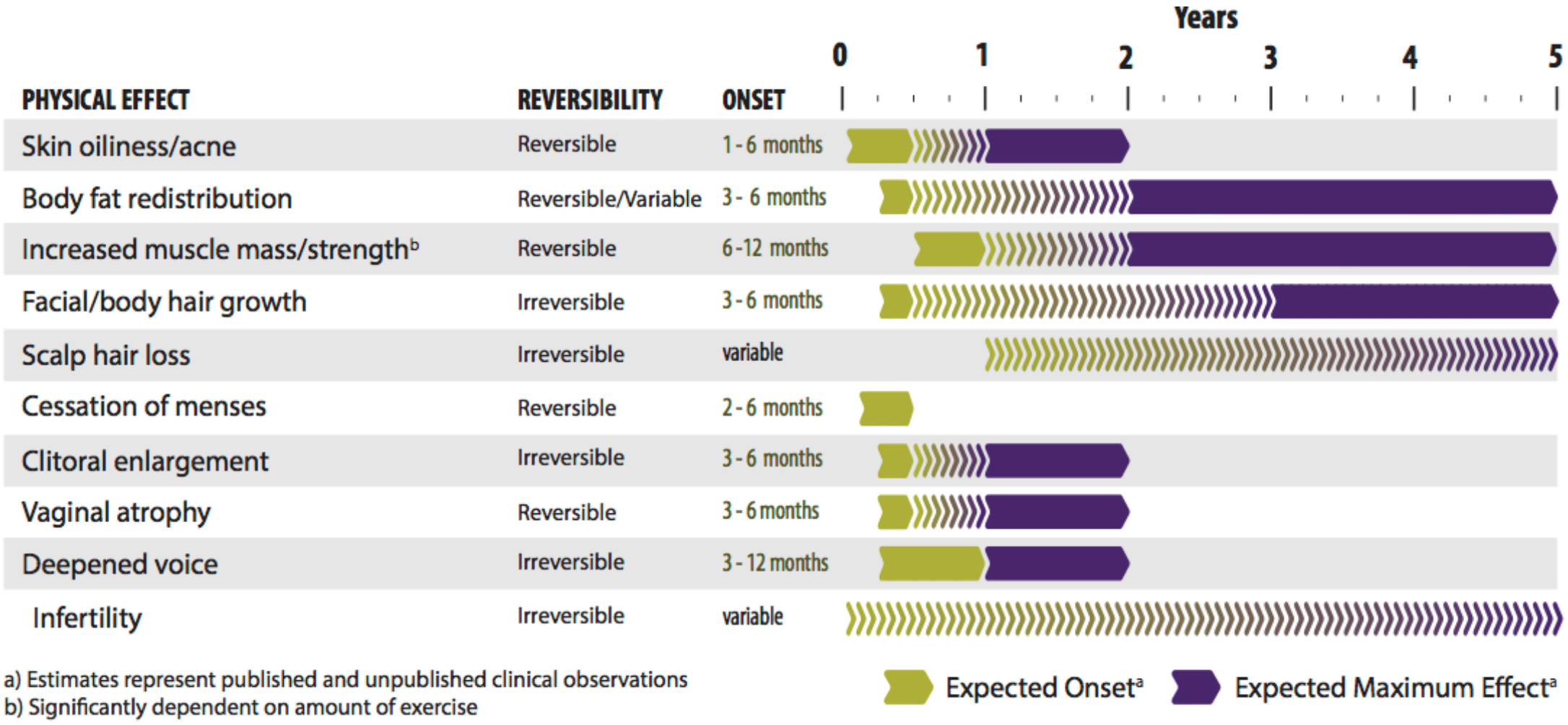
Hormone Therapy: Female to Male

- 1 drug: Testosterone
- Can do injections or transdermal
- Injections are cheaper, can do subQ or IM.
- Weekly or every 2 weeks
- Transdermal: daily, more expensive, dermal absorption is variable. Have to be cautious about gel not touching partners/kids/pets
- Monitor levels for a trough testosterone level between 400-700

Testosterone therapy (my practice)

- Start 25mg SubQ testosterone weekly (depends on which guidelines you read!)
- Dose adjust every 6-8 weeks with a goal of mid-dose injection total testosterone levels of 400-700ng/dL
- Usual dose is between 50-100mg weekly (some do injections every 2 weeks, with double the dose)
- Prior to starting: CBC, CMP, A1c, Lipid panel (+/- estradiol, testosterone baseline)
- Lab monitoring: ALT, HCT, Total testosterone
- Once on stable regimen, can space labs to q6months, and then q12months

Timeline of expected changes



Surgical Therapy: Female to Male

- Mastectomy with chest reconstruction
- Metoidioplasty (uses current tissue from clitoral enlargement to make a neo-phallus)
- Phalloplasty (uses graft tissue, usually radial/forearm to make a neophallus)
- More on this in a future webcast by Dr. Julian Winocour

Treatment considerations Male to Female

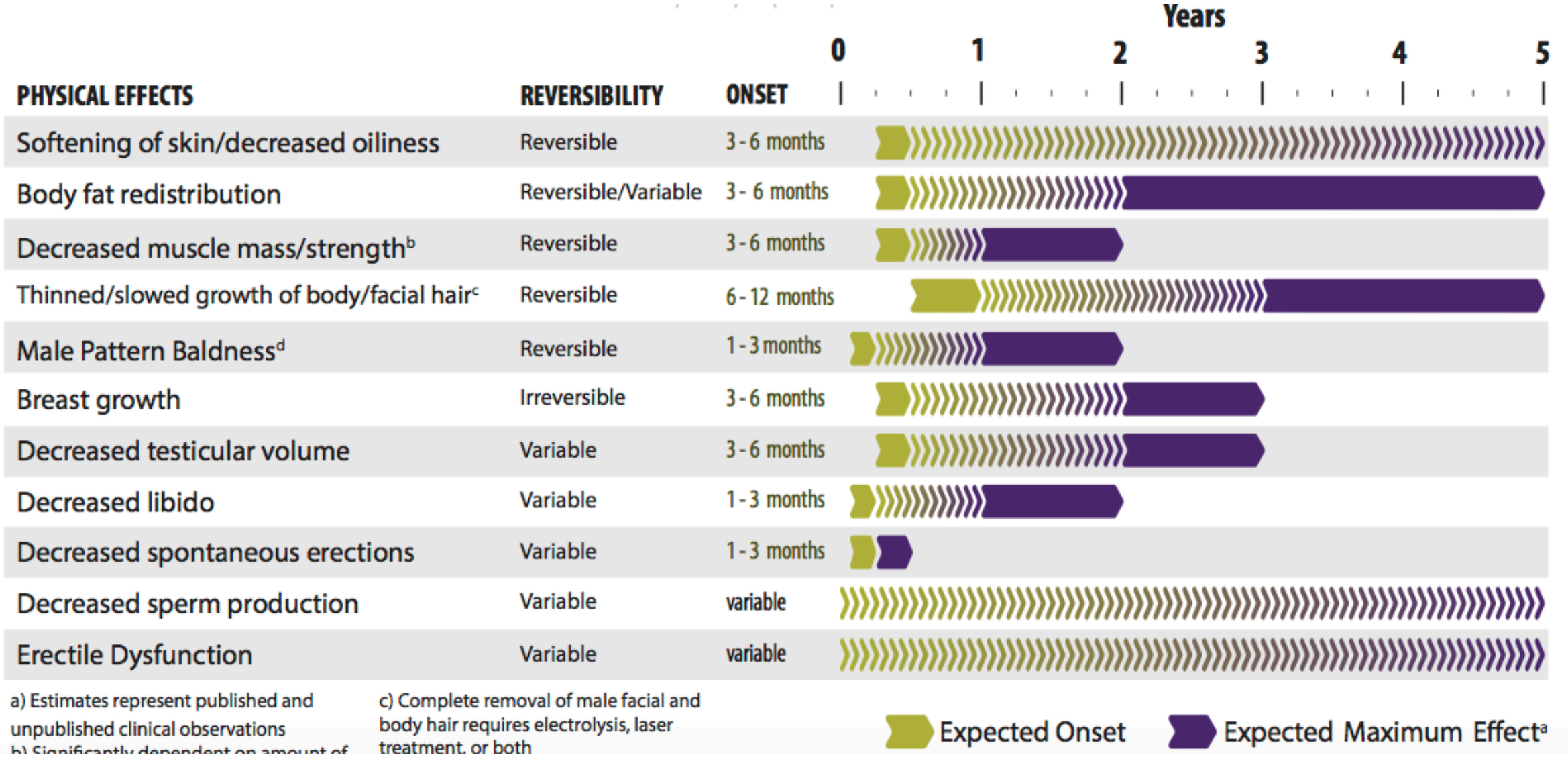
Hormone Therapy: Male to Female

- Goal: suppress testosterone, add estrogen
- Androgen blockers: sprinolactone used most frequently
  - Monitor BMP, BP
- Estrogen: pills, patches, injections each with risks and benefits
- Pills are easy and CHEAP ($4 generic list at Wal-Mart, but highest risk of VTE)
- Injections can be subQ, usually weekly (dosing is different for estradiol cypionate vs estradiol valerate)
- Progesterone: data isn't great, may have some use with breast/nipple contour when first beginning treatment, increases VTE risk. Short term use only

The controversy of Estradiol levels.

- No real consensus
- Endocrine guidelines: goal for estradiol level between 100-200pg/dl
- Many others smart people aim goal of 300-500pg/dl
- Planned Parenthood approach: based on symptomatic response without lab monitoring
- My practice: still figuring it out! If patient's are unhappy a level between 100-200, can consider targeting higher levels

Timeline of Expected Changes



Ancillary considerations

- Voice therapy
- Hair removal- laser vs electrolysis
- Hair transplant for bald/balding transwomen

Surgical Therapy: Male to Female

- Electrolysis/laser hair removal
- Facial feminisation surgery
- Tracheal shave
- Breast augmentation, chest reconstruction
- Orchiectomy
- Penectomy
- Vaginoplasty

Non-binary patients

- Patients that may not identify with either sex, or identify with features of both sexes
- Often prefer they/them pronouns
- THE SAME RULES APPLY!
- “What are your transition goals and how can I help you get there?”
- Low doses of HRT, chest surgery are often desired.

Peds Case #1

4yo caucasian female presents to PCP for WCC. Mother is concerned that the patient only wants to wear her brother's clothes. She tells people she wants to be a man when she grows up, and corrects everyone who calls her pretty to tell her that she's handsome. The mom has even caught the child stuffing a pair of socks in her underwear to make it look like she had a penis. The mother is very concerned and wants to know if this is just a phase or something more serious.

What do you do for this patient? What do you tell mom?

Social transitioning

- Reversible
- Child lives as their identified gender by adopting hairstyle, clothing, pronouns, possibly new name
- Requires plan for disclosure to friends and family, cooperation with school

Peds Case #2

Now your patient is 11 years old and is here for WCC. She has a short haircut, is wearing boy's clothes and remains persistent that she identifies as male. On exam she has tanner stage 2 breast and pubic hair development. She has not had her first menstrual period. HEADSS assessment is positive for bullying and feelings of isolation. She has tried smoking cigarettes with some older kids at school. She is active in athletics, specifically soccer and basketball.

Now, how is this case different?
What do you tell mom?

Gender dysphoria that intensifies with puberty, will rarely subside.

Persistent. Insistent. Consistent.

Puberty suppression: GNRH agonists

- Prevents the development of secondary sexual characteristics that may result in increased body dysmorphia and comorbid anxiety and depression
- Prevents secondary sexual traits would require multiple surgeries to reverse if patient were to fully transition (i.e. breast removal, electrolysis)
- Allows the patient and family more time to fully explore the patient's gender identity
- Completely reversible

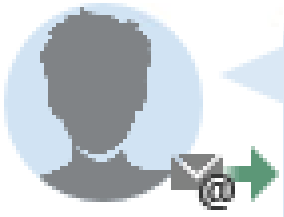
Cross Gender Hormone Therapy

- Requires good psychosocial support, stable mental health, responsible medication compliance, informed consent of risks etc.
- If the patient underwent pubertal suppression, some benefit to starting at the time when age matched peers would also be going through puberty, other guidelines recommend to start at 16
- Patient will be infertile if previously underwent pubertal suppression
- If patient underwent natural puberty, can start hormones at any time

Some meaningful stories/quotes

- “I’ve known I was a woman all of my life. The first time I tried coming out as trans to my parents I was 17, they scheduled the exorcism for that night. And then three more after that.”
- “I came out as trans in the 1990s. I got a breast augmentation and was living as a woman. My dad died in the early 2000s. My mom said to me, you can either continue to do this or you can choose your family. I was scared. I missed my dad. I didn’t want to lose my mom too. She gave me the money to get my implants taken out. I went back to the surgeon, and he just looked at me- like what are you doing here? I said, don’t ask. Just take them out. Now 15 years later, I’m finally ready to live my authentic true self.”

And the #1 reason why I do this.



I am the proud owner of a new id that has my proper gender marker! I literally could not have done it without you. Thank you! Thank you for being kind and taking the time to email me and rewrite notes and read test results and help a community that goes ever so regularly overlooked or ignored. You see me, as a person, and I see you and all your hard work right back. You're a good doctor. Really.

8:44 PM

RECAP Final points

- Be nice, compassionate physicians, nurses, providers. These patients often have negative interactions with healthcare providers
- Ask your TG patients what transitioning means to them, individual decisions different for each pt. Ask them how you can help them reach their goals.
- Screen your TG patients based on the anatomy/organs/tissue that they have
- Ask about pronouns, use them. Apologize if you mess up (you will) and move on.
- Like my patients, my clinic is always in transition! We are learning to be patient and enjoy the journey. We have learned so so much.

Resources

- UCSF Guidelines
- Endocrine Society
- WPATH/USPATH (World/US Professional Association of Transgender Health)
- Rainbow Health Ontario
- Fenway Health
- University of British Columbia
- Facebook! (seriously)

Works Cited

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- Sherer, Ilana et al. “Affirming gender: Caring for gender-atypical children and adolescents.” Contemporary Pediatrics. January 2015.
- Rainbowhealthontario.ca

EXHIBIT 1-G

(Conventionally Filed)

EXHIBIT 1-H

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

BONGO PRODUCTIONS, LLC, ROBERT BERNSTEIN, SANCTUARY PERFORMING ARTS LLC, and KYE SAYERS, Plaintiffs, v. CARTER LAWRENCE, Tennessee State Fire Marshal, in his official capacity, CHRISTOPHER BAINBRIDGE, Director of Codes Enforcement, in his official capacity, GLENN R. FUNK, District Attorney General for the 20th Judicial District, in his official capacity, and NEAL PINKSTON, District Attorney General for 11th Judicial District, in his official capacity, Defendants.	)	Civ. Action No. 3:21-cv-00490 Judge Trauger

DECLARATION OF SHAYNE SEBOLD TAYLOR, MD

Preliminary statement

1. My name is Shayne Sebold Taylor, MD. I have been retained by counsel for Plaintiffs as an expert in connection with the above-mentioned litigation. I have actual knowledge of the matters stated herein.
2. I am an Assistant Professor of Internal Medicine and Pediatrics at Vanderbilt University Medical Center and the Monroe Carrell Jr. Children's Hospital at Vanderbilt in Nashville, Tennessee.
3. I am licensed in the state of Tennessee to practice medicine (TN License #55151).

4. I am board certified in both Internal Medicine and Pediatrics by the American Board of Internal Medicine and the American Board of Pediatrics, respectively.
5. I obtained my undergraduate degree at Emory University with a BS in Biology and a BA in Women and Gender Studies. I received my medical degree from Drexel University College of Medicine and completed my Internal Medicine and Pediatrics residencies at Vanderbilt University Medical Center.
6. I have lived and practiced medicine in the state of Tennessee since 2014.
7. Additional information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as Exhibit A to this report. In conjunction with serving as an Assistant Professor of Internal Medicine and Pediatrics at Vanderbilt, I am the creator and Lead Clinician of the Vanderbilt Clinic for Transgender Health, a multi-disciplinary patient-centered medical home for transgender adults. My clinical duties include providing primary care and transition-related care (particularly hormone therapy), as well as providing care navigation with specialists across the Vanderbilt medical community. I have over 700 transgender patients under my care with a 3-6 month waitlist to be seen for services. The majority of my patients reside in Middle TN, however I have patients traveling 3-4 hours to come to the clinic spanning from Memphis to the west and Kingsport to the east.
8. In addition to my clinical work, I provide guidance to physicians throughout Vanderbilt and Middle Tennessee who care for transgender patients. I do this by giving grand rounds, presentations to medical students and residents, and training to various community providers on the importance of culturally competent care for the transgender patient.

9. As part of my practice, I stay current on medical research and literature relating to the care of transgender persons and patient's suffering with gender dysphoria.
10. I am a member of the World Professional Association of Transgender Health (WPATH), American Academy of Pediatrics (AAP), American College of Physicians (ACP), Alpha Omega Alpha (AOA) medical honor's society, and the Gay and Lesbian Medical Association (GLMA).
11. I am being compensated $350/hour for my time preparing this testimony. My compensation does not depend on the outcome of the litigation, the opinions I express, or the testimony I provide.

Sex, Gender, and Gender Identity

12. The sex of a child is most often determined after delivery based on the visual appearance of an infant's external genitals.
13. Research has identified that determination of sex is far more complex than what is seen on genital exam. Instead, sex is a complex compilation of multiple factors including one's chromosomal make up (XX for those assigned female at birth, XY for those assigned male at birth), gonadal sex (presence of ovaries or testes), fetal hormonal sex (production of sex hormones *by* the fetus or exogenous exposure of sex hormones *to* the developing fetus), pubertal hormonal sex (the change in hormonal milieu that results in the development of secondary sexual characteristics- facial hair and deep voice for those assigned male at birth, breasts and menstrual cycles for those assigned female), hypothalamic sex (variations in brain structure and function as a result of embryonal exposure of sex hormones), and gender identity.

14. For each of the above factors that contribute to the development of sex, there can be variations. Sex related characteristics do not always align as either completely male or completely female. For example, many children are born with ambiguous genitalia, and as a result it is difficult to assign these infants as either male or female at birth. These patients are often identified as intersex, which is one of many disorders of sexual development (DSD). These children often see multiple specialists throughout their lifespan. Other examples of DSDs are those of chromosomal differences. The typical human chromosomal make up includes 46XY for males and 46XX for females. However, in male patients with Kleinfelter's syndrome their chromosomal makeup is 47XXY. These chromosomal male individuals have an extra X chromosome. The results include breast development and small testes, in addition to other physical findings. Patients with Turner Syndrome are 45XO. These female individuals are missing an X chromosome, and as such many of them do not develop normal female puberty and are often infertile. These variations are common. The Monroe Carrell Children's Hospital at Vanderbilt has an entire clinic to cater to the medical needs of this patient population.
15. Gender identity is a person's inner sense of belonging to a particular gender. Identifying as male or female is a core component of one's overall identity. Every person has a gender identity. Research has shown that children begin to develop and express their gender identity during their toddler years, at around the age of 3 years old. It has a strong biological basis and cannot be changed.
16. Scientific research has discovered many biological reasons for how an individual develops a gender identity. Complex interactions between hormones, chromosomes, and the developing embryo in utero are at the center of these theories.

17. From a medical perspective, in the event that one's gender identity does not match their sex assigned at birth, i.e. in transgender people, one's gender identity should be the determining factor of their sex. The medical consensus recognizes that when one's sex related-characteristics are not in alignment, a person's gender identity is the determining factor, more important than the presence of their genitals, their chromosomal analysis, or their hormone levels.

Gender Dysphoria and its Treatment

18. Transgender people have a gender identity that differs from the sex that was assigned to them at birth.
19. This lack of alignment of assigned sex and gender identity can result in severe distress, depression, anxiety. This constellation of symptoms is termed gender dysphoria.
20. Treating gender dysphoria results in significant improvement in the quality of life, mental and physical health of transgender persons. Transgender people undergoing treatment for their gender dysphoria can live long, happy, productive and meaningful lives.
21. Gender transition for those that suffer from Gender Dysphoria is a lengthy process with multiple components. These components may include social transition, medical transition, and surgical transition. Each transgender individual approaches transition differently, as the decision to undergo any aspect of transition is deeply personal and depends on the degree and type of dysphoria the patient is experiencing.
22. The social transition is a formative aspect of a transgender person's experience. Social transition can include going by a different name, using different pronouns, or changing one's haircut, or clothing to match one's gender identity.

23. As part of the social transition, a transgender individual will make changes that will allow them to seamlessly incorporate into their communities with a presentation that matches with their gender identity. This may mean using a restroom facility that matches their gender identity, in the same way that a non-transgender person uses the bathroom that matches their gender identity.

24. In addition to social transition, transgender individuals often interface with a healthcare setting for medical or surgical intervention. Medical transition often includes the prescription of hormones so that the transgender person can develop secondary sexual characteristics of the sex with which they identify. This may mean that a transgender man (or someone who was assigned female at birth) may grow facial hair and develop a much deeper voice as a result of testosterone treatment. Alternatively, transgender women (assigned male at birth), may develop breast tissue and a more feminine body fat distribution as a result of estrogen that may be prescribed by a clinician.

25. Some transgender patients seek surgical transition. These surgical procedures further change the patient's anatomy so that their outward appearance matches more closely with their gender identity.

26. Given the medical and surgical treatments that transgender patients may encounter, they are often no longer presenting as their sex assigned at birth. This will further create stress and anxiety for bathroom users, both transgender and otherwise. An example is as follows: a transgender man has been on testosterone therapy for many years. As a result, he has a full-grown beard. He has also had surgical removal of his breast tissue. He wears men's clothing and speaks in a deep voice. It is harmful for that man to have to use a woman's restroom.

Transgender in Tennessee

27. According to a Williams Institute study in 2016, there are approximately 1.6 million people in the United States that identify as transgender. In this same study, it was revealed that an estimated 31,000 transgender people (or 0.6% of the state's population) live in the state of Tennessee. Tennessee is ranked 10th in the nation for its percentage of transgender individuals (Hawaii being the highest and North Dakota with the lowest).

28. H.B. 1182 requires a sign that specifically mentions the term "biological sex." This term has no place or meaning in either science or medicine, because experts who study sex and gender understand that the biology and identity of a human being is far more complex than what can be identified on an individual's genital anatomy or chromosomal evaluation. Having this controversial political term, one that has no value or meaning in medicine or science, posted on every public bathroom in the state of Tennessee is dangerous and distressing, further running the risk of worsening gender dysphoria for those that suffer from the condition.

29. The 31,000 transgender individuals in Tennessee work in Tennessee businesses, go to Tennessee schools and are active members of their families, communities and churches to name a few. Transgender Tennesseans deserve privacy when they use the restroom. Using the restroom at a business is often necessary and should be routine. A transgender patron should not have to effectively disclose their transgender status by using the designated restroom that matches their sex assigned at birth. A transgender person should be able to use the restroom that matches with their gender identity. A large posted sign referencing "biological sex" on every business is stigmatizing and isolating for

transgender Tennesseans. The Act that goes into law on July 1, 2021 is harmful and dangerous for these members of our community.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: June 21, 2021

Shayne Sebold Taylor, MD

Shayne Sebold Taylor, M.D.
Curriculum Vitae

Contact Information:

Office Address: Vanderbilt Internal Medicine and Pediatrics
7069-B Highway 70S
Nashville, TN 37221
Office Phone: (615) 538-3668
Email Address: shayne.s.taylor@vumc.org

EDUCATION

Undergraduate:

EMORY UNIVERSITY, Atlanta, GA
Degree: Bachelor of Science in Biology and
Bachelor of the Arts in Women and Gender Studies
Dates: August 2006 – May 2009

CONNECTICUT COLLEGE, New London, CT
Dates: August 2005 – May 2006

Professional or Graduate School:

DREXEL UNIVERSITY COLLEGE OF MEDICINE, Philadelphia, PA
Degree: Doctor of Medicine
Dates: August 2010 – May 2014

Postgraduate Training:

VANDERBILT UNIVERSITY, Nashville, TN
Internal Medicine & Pediatrics Internship & Residency Program
Dates: July 2014-August 2018

LICENSURE AND CERTIFICATION

- TN Medical License (# 55151) 1/14/2016-09/30/2020
- Board Certification American Board of Pediatrics 10/2018
- Board Certification American Board of Internal Medicine 08/2019

ACADEMIC APPOINTMENTS

Assistant Professor of Medicine
VANDERBILT UNIVERSITY SCHOOL OF MEDICINE, Nashville, TN
August 2018 – present

HOSPITAL APPOINTMENTS

Active Medical Staff
VANDERBILT UNIVERSITY SCHOOL OF MEDICINE, Nashville, TN
August 2018 – present

PROFESSIONAL ORGANIZATIONS

- American Academy of Pediatrics (AAP)
- American College of Physicians (ACP)
- Alpha Omega Alpha (AOA)
- Cumberland Pediatrics Foundation (CPF)
- National Med-Peds Residency Association (NMPRA)
- Gay and Lesbian Medical Association (GLMA)
- World Professional Association for Transgender Health (WPATH)

PROFESSIONAL ACTIVITIES

- Vanderbilt University, Med-Ped Residency Program
  - Physicians for Reproductive Health Board Member, 2014-2017
  - LGBTI Health Provider, 2015-present
  - World Professional Association for Transgender Health (WPATH) Conference Attendee, February 2016
  - Nexplanon Resident Education Organizer, 2016-2017
  - Vanderbilt Gender Clinic Committee Member, 2016-present
  - Page Campbell Moonlighter, 2016-2018
  - Bioethics Certificate Program Participant, 2017-2018
  - Med-Peds Wellness Chief, 2017-2018
- Vanderbilt University Medical Center
  - Lead clinician, Vanderbilt Clinic for Transgender Health 2018-present
    - Providing direct clinical care to >600 transgender patients in the Southeast region
    - Coordinating care between all specialties at VUMC for transgender care
    - Regional consultant to local primary care physicians
- Expert witness to Lambda Legal 2020-present

AWARDS AND SPECIAL RECOGNITION

- Writer's Award from The Emory University President's Commission on the Status of Women, "*Young Venuses and Old Hags: a feminist critique on the media's portrayal of aging women*," 2009
- Pathology Honor Society at Drexel University, 2010
- The Lila Kroser Scholarship at Drexel University, 2013
- The Drexel University Peer Commendation for Professional Behavior, 2014
- Alpha Omega Alpha, Drexel University College of Medicine, 2014

- Excellence in Patient Experience, VUMC 2020

TEACHING ACTIVITIES

- Creator for the LGBTQ Health Curriculum for Residents, 2017-present
- Research mentor to Mollie Limb, VUSM student, 2018-present
- QI research mentor to Kalin Wilson, VUSM student, 2018-present
- Faculty partner with Internal Medicine Residency Social Medicine Club 2019
- Contributor to Internal Medicine Resident Handbook 2019
- Foundations of Healthcare Delivery faculty
- Integrated Science Course faculty
- ACE primary care rotation faculty

PUBLICATIONS AND PRESENTATIONS

Presentations:

"Caring for the Transgender Patient: With little evidence, but a lot of love." Vanderbilt University Division of Infectious Disease Grand Rounds and Division of General Internal Medicine Grand Rounds, 4/4/2019 and 5/22/2019.

"A Primer for Transgender Health." Southeast/TN AIDS Education and Training Center, webcast 1/30/2019.

"The Clinic for Transgender Health: A Passion Project for our Patients." Vanderbilt University Program for LGBTQ Health Grand Rounds, 11/14/2018.

"Caring for the Transgender Patient." Vanderbilt University School of Nursing, 10/23/19.

"Caring for the transgender patient, with little evidence but a lot of love. Lessons learned creating a Transgender Health Clinic in the South." American College of Osteopathic Obstetricians and Gynecologists. Virtual Presentation 3/20/2020.

Articles in Refereed Journals:

Taylor, S.S., Ehrenfeld, J.M. "Electronic Health Records and Preparedness: Lessons from Hurricanes Katrina and Harvey" Journal of Medical Systems. (2017) 41:173.

Gamble, R, **Taylor SS**, Ehrenfeld J.M., Huggins, A. "Trans-specific Geriatric Health Assessment (TGHA): An inclusive clinical guideline for the geriatric transgender patient in a primary care setting." Maturitas, Volume 132, 70 - 75

RESEARCH PROJECTS

Healthcare Needs and Barriers Among New Patients at a Clinic for Transgender Health
IRB NUMBER: 192299
PI: Shayne Taylor

Assessing LGBTQ+/Racial Minority Trainee's Experiences with Social Support, Loneliness, and Feelings of Anxiety or Depression During Training
IRB #210225
PI: Hannah Lomzenski
Faculty Advisor: Shayne Taylor

EXHIBIT-I

615-237-5552 ESPAÑOL

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Transgender-Female to Male Before & After Pictures

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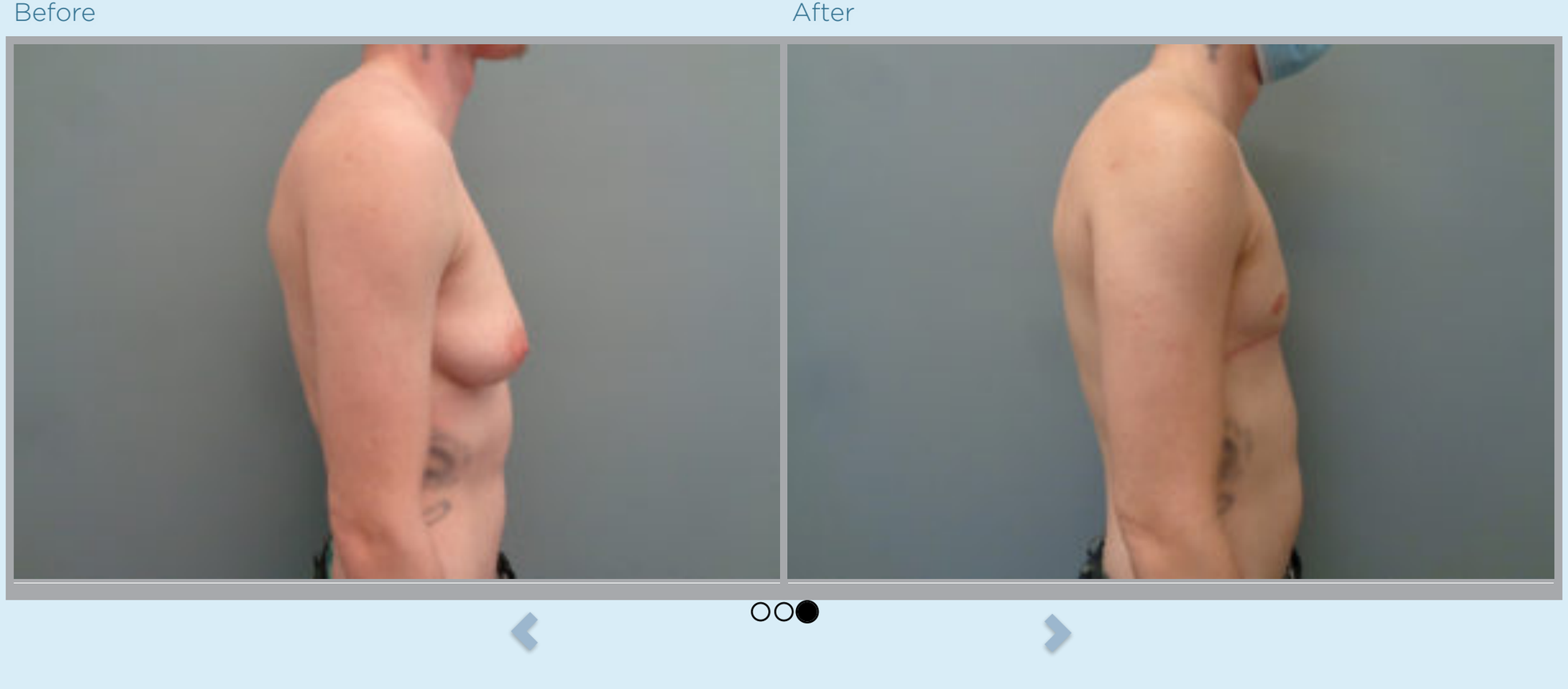
Home — Plastic Surgery Before and After Pictures in Nashville, TN — Transgender-Female to Male Before & After Pictures In Nashville, TN

TRANSGENDER-FEMALE TO MALE BEFORE & AFTER PICTURES IN NASHVILLE, TN

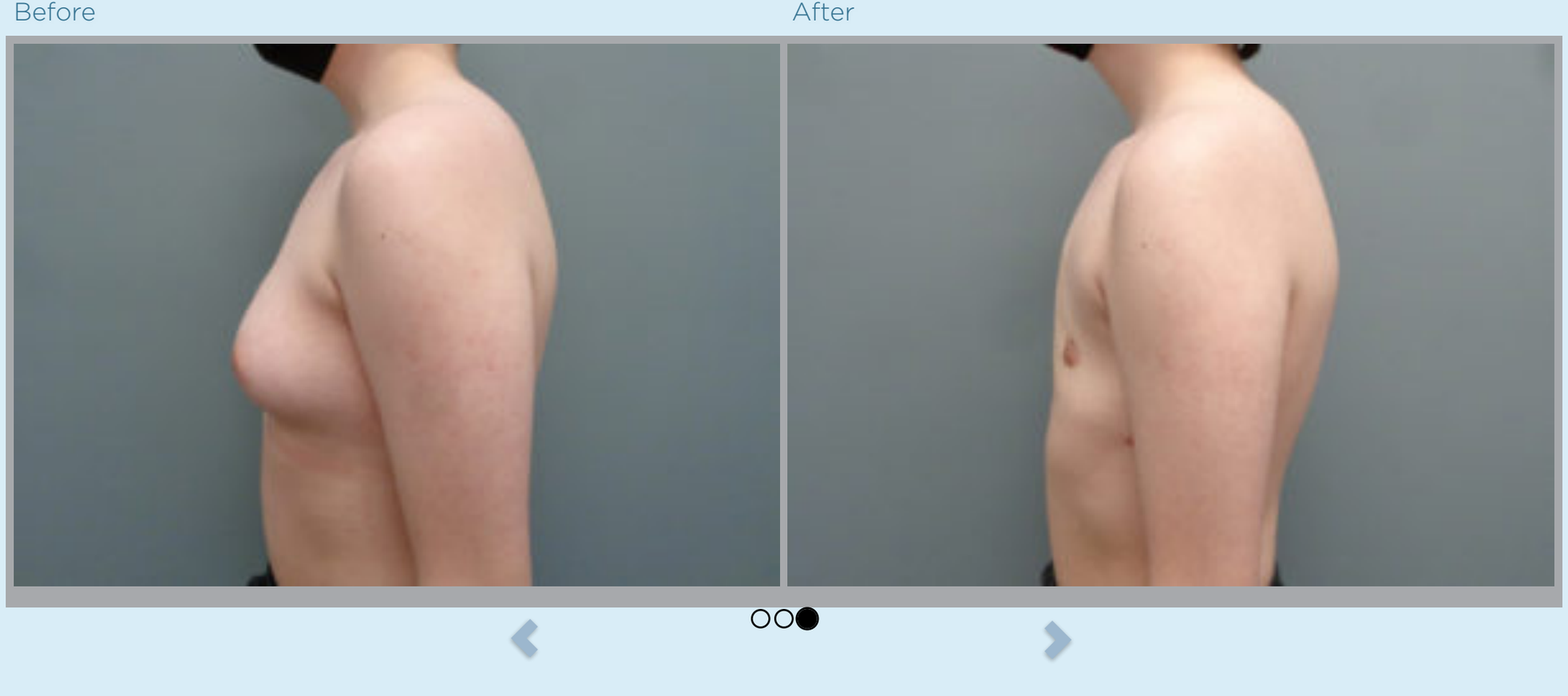
Patient 7437: 28 year old female who underwent removal of breast tissue as well as liposuction.

Before After



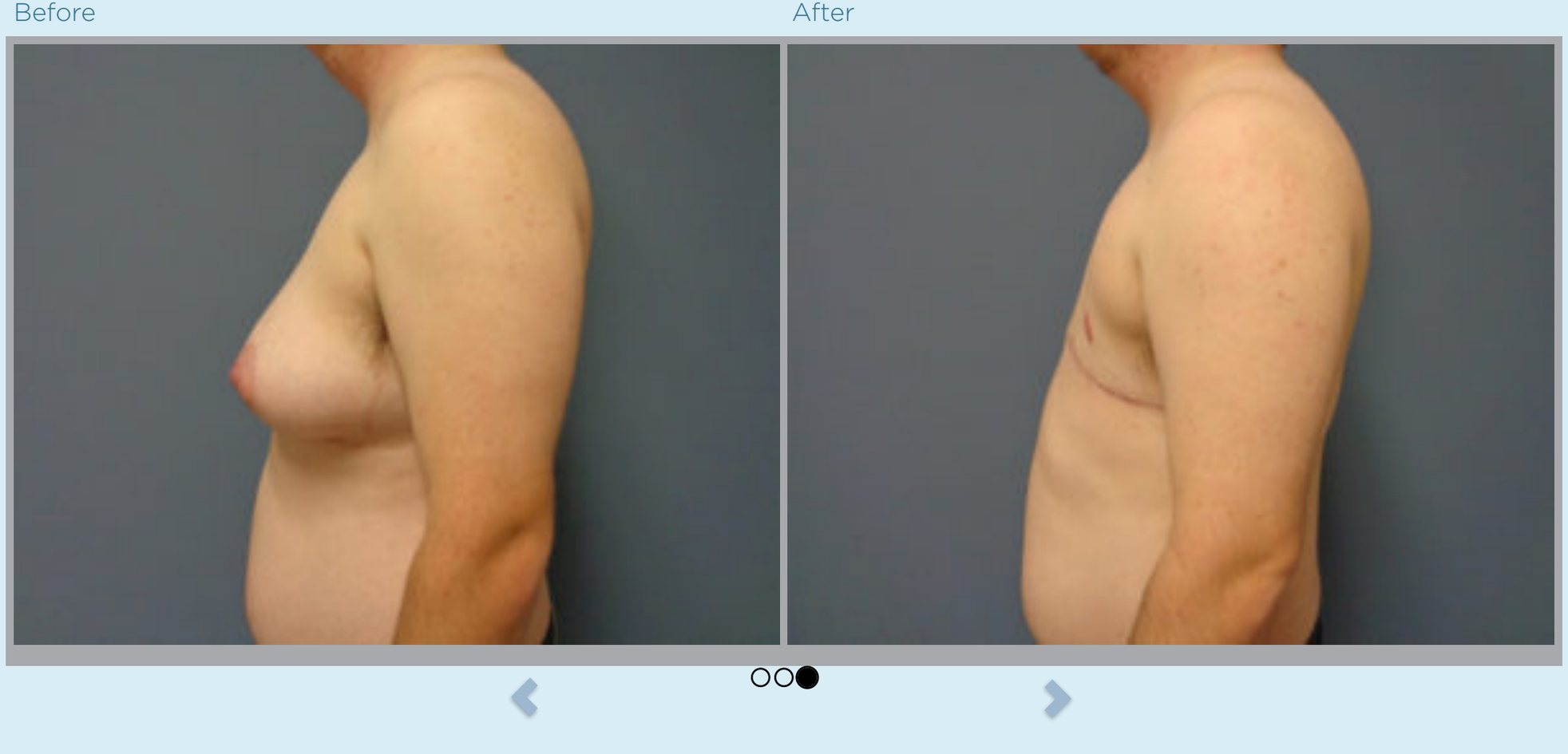
Patient 10237: 15 year old female to male who underwent removal of breast tissue.

Before After



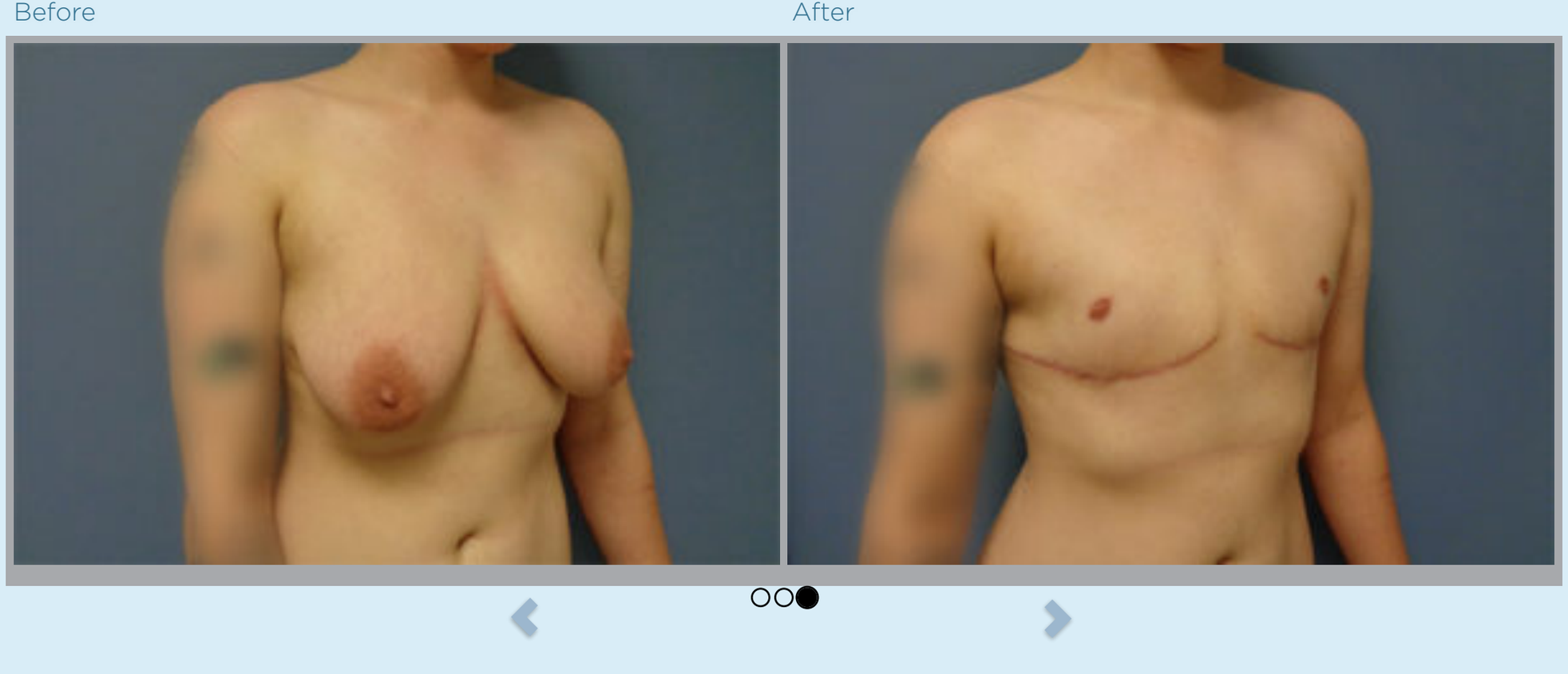
Patient ST486819: 29 year old female to male who underwent removal of breast tissue as well as liposuction.

Before After



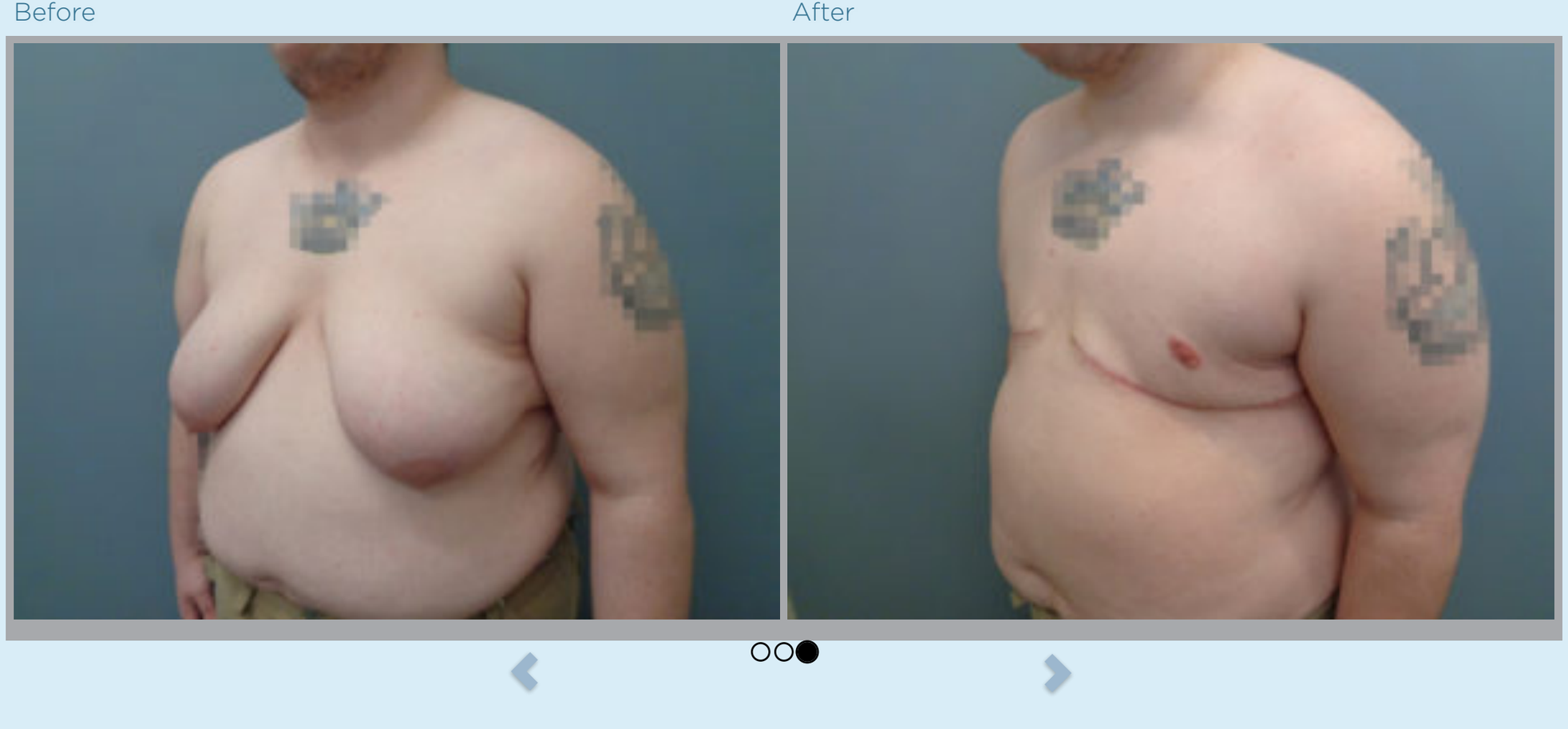
Patient 5869: 20 year old female to male who underwent removal of breast tissue as well as liposuction.

Before After



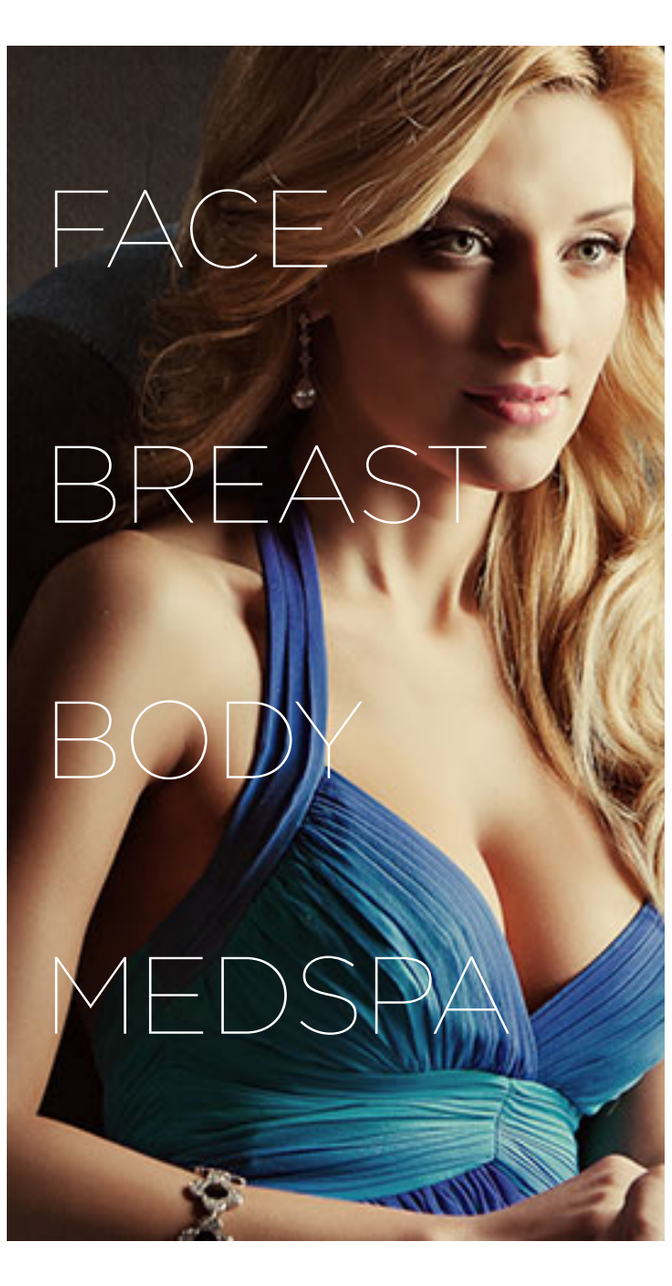
Patient 6635: 24 year old female to male who underwent removal of breast tissues as well as liposuction.

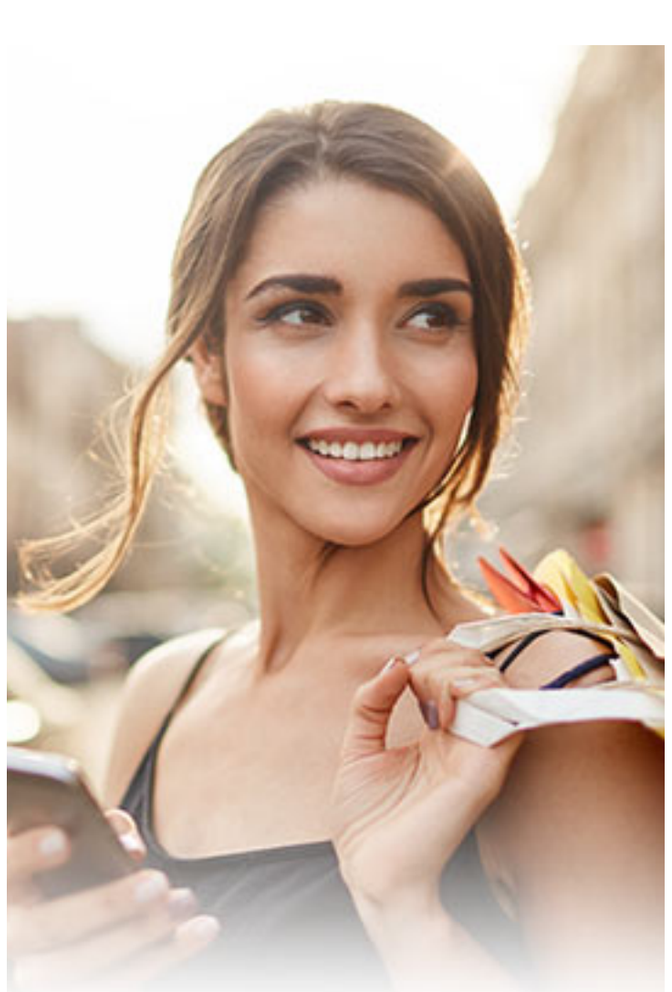
Before After



MEET
Doctor Chad Robbins
Board Certified Plastic Surgeon

READ MORE





MEDSPA

SKIN STORE

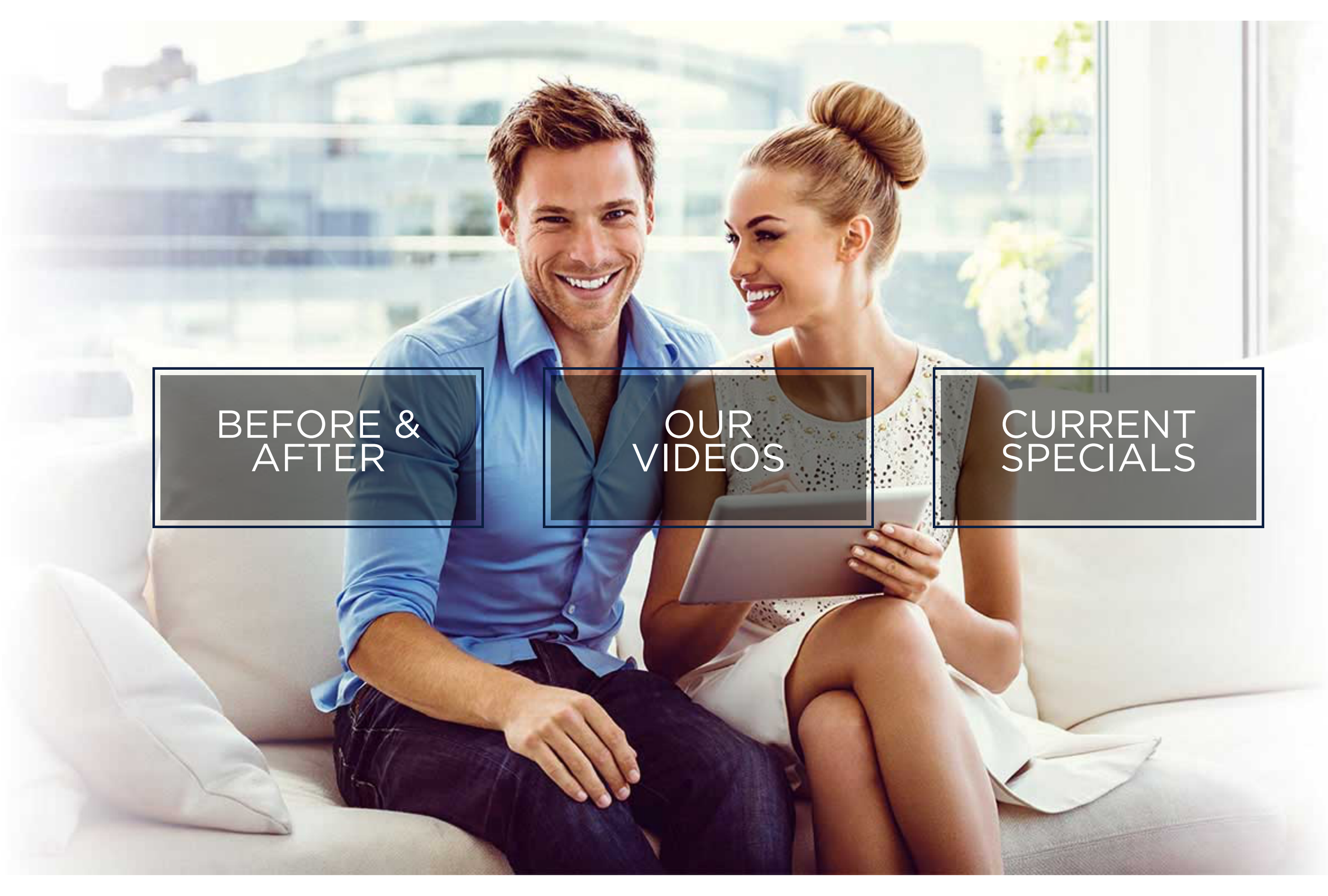


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EXHIBIT 1-J

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE

L.W., *et al.,*	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Civil Action No. 3:23-CV-00376**
	)	
JONATHAN SKRMETTI,	)	
	)	
Defendant.	)	

DECLARATION OF C. WRIGHT PINSON, MBA, MD

I, C. Wright Pinson, MBA, MD, hereby state as follows:

1. My name is C. Wright Pinson, MBA, MD. I am over the age of eighteen and have personal knowledge of the facts set forth herein.

2. I am the Deputy CEO and Chief Health System Officer of Vanderbilt University Medical Center ("VUMC"), an academic medical center with its principal offices in Nashville, Tennessee. I have served in this capacity from April 30, 2016 to the present. In this role I have senior management responsibility for all aspects of the health care business and operations of VUMC.

3. I am submitting this Declaration in connection with the lawsuit captioned above.

4. I am familiar with the provisions of 2023 Public Chapter 1, codified at Tenn. Public Acts §§ 68-33-101, *et seq.* (hereafter, the "Act").

5. The Act prohibits a healthcare provider on and after July 1, 2023 (the "Effective Date") from knowingly performing or administering any "medical procedure" (as defined in § 68-33-102(5) of the Act) to a minor, if the performance or administration of

that medical procedure (as defined in the Act) is for the purpose of enabling a minor to identify with or live as a gender other than their sex at birth, *or* treating discomfort or distress from discordance between a minor's assigned sex and their asserted identity. As defined in the Act, "medical procedure" includes, but is not limited to, prescribing, administering or dispensing any puberty blocker (as further defined in the Act) or hormone (as further defined in the Act) (collectively referred to herein as "Hormone Therapy").

6. Notwithstanding the prohibition discussed immediately above, the Act provides that a medical procedure (as defined in the Act) which commences before the Effective Date may continue to be performed or administered to a minor patient through March 31, 2024, if the minor's treating physician determines that ending the medical procedure would be harmful to that specific patient. Pursuant to Section 68-33-103(b)(3) of the Act, this determination must be certified by the treating physician, must include specific findings by the treating physician which support such determination, and must be documented in the individual minor patient's medical record (the "Continued Care Exception").

7. After the Act was signed into law, VUMC reviewed the Act and determined that on and after the Effective Date it could no longer offer any Hormone Therapy to minor patients. VUMC has communicated this determination to its patients through communications distributed through various media (including the US Mail, and electronically to existing patients sent through MyHealth@Vanderbilt®, VUMC's digital patient health information portal).

8. As of the date of this Declaration, no minor patient of VUMC has been identified who will continue to receive Hormone Therapy at VUMC following the Effective Date in reliance on the Continued Care Exception.

9. Should enforcement of the Act's provisions prohibiting Hormone Therapy be deferred, delayed or enjoined, VUMC would continue to provide Hormone Therapy consistent with prevailing standards of care for persons with gender dysphoria to those minor patients of VUMC for whom such care is clinically appropriate, given the assessment of the patient's condition.

I, C. Wright Pinson, MBA, MD, hereby declare under the penalty of perjury that the foregoing is true and accurate.

C. WRIGHT PINSON, MBA, MD

5/11/23
DATE

35651812.3

EXHIBIT 1-K

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE

L.W., *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**Civil Action No. 3:23-CV-00376**
	)	
JONATHAN SKRMETTI,	)	
	)	
Defendants.	)	

DECLARATION OF CASSANDRA C. BRADY, MD

I, Cassandra C. Brady, MD, hereby state as follows:

1. My name is Cassandra C. Brady, MD. I am over the age of eighteen and have personal knowledge of the facts set forth herein.

2. I am an Assistant Professor of Clinical Pediatrics at Vanderbilt University Medical Center ("VUMC"), an academic medical center with its principal offices in Nashville, Tennessee.

3. I received my medical degree from Indiana University School of Medicine and completed my residency in General Pediatrics at Monroe Carrell Jr. Children's Hospital at Vanderbilt. I then completed a fellowship in Pediatric Endocrinology at Cincinnati Children's Hospital Medical Center.

4. I have been licensed to practice medicine in the State of Tennessee since 2015. I am board certified in both General Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics.

5. I am a member of the American Academy of Pediatrics, the Endocrine Society, and the Pediatric Endocrine Society. I am also a member of the World Professional Association for Transgender Health ("WPATH").

6. I have been treating patients with gender dysphoria since 2012, and I have extensive experience in the treatment of adolescents with gender dysphoria. My clinical duties at VUMC have included providing gender-affirming care such as puberty blocking and hormone treatments to transgender/gender diverse youth with gender dysphoria.

7. I believe 2023 Public Chapter 1, codified at Tenn. Public Acts §§ 68-33-101, *et seq.* (hereafter, the "Act"), is harming my transgender/gender diverse patients by interfering with their ability to receive necessary medical care in accordance with recognized standards of care for transgender persons, including WPATH Standards of Care Version 8.

8. Prior to the passage of the Act, I had over 200 transgender/gender diverse patients under my care. After the Act was signed into law, VUMC reviewed the Act and determined that on and after July 1, 2023, when the Act takes effect (the "Effective Date"), it would no longer offer Hormone Therapy (as defined in Dr. C. Wright Pinson's Declaration of May 11, 2023) to minor patients. VUMC has communicated this determination to patients.

9. As of the date of this Declaration, I have not identified minor patients who will continue to receive Hormone Therapy at VUMC following the Effective Date in reliance on § 68-33-103(b)(3) (the "Continued Care Exception") for several reasons, including that some of my minor patients have not returned to clinic since the Act was passed and many are already seeking care out of state. For those who are unable to

seek care out of state, weaning from Hormone Therapy has begun, but it is too soon to determine whether they can be weaned from their medications by the Effective Date without harm.

10. Additionally, I am concerned that my determination that a patient meets the Continued Care Exception could subsequently be deemed by non-medical third parties to violate the Act, which could expose me to punitive consequences.

I, Cassandra C. Brady, MD, hereby declare under the penalty of perjury that the foregoing is true and accurate.

CASSANDRA C. BRADY, MD

5/18/23
DATE

EXHIBIT 1-L

VANDERBILT UNIVERSITY MEDICAL CENTER

C. Wright Pinson, M.B.A., M.D.
Deputy Chief Executive Officer and
Chief Health System Officer

October 7, 2022

Representative Zachary,

I write in response to your letter of September 28, 2022 on behalf of Vanderbilt University Medical Center ("VUMC") and its Board of Directors regarding the concerns about surgical care provided through the transgender clinic for those under age 18.

VUMC began its Transgender Health Clinic in 2018 because transgender individuals are at high risk for mental and physical health issues, and have been consistently underserved by our nation's healthcare systems. Among those patients under 18 receiving transgender care, an average of 5 per year have received gender-affirming surgical procedures. Contrary to some media reports, all were at least 16 years of age, none have received genital procedures and parental consent to these surgeries was obtained in all cases. None of these surgeries have been paid for by state or federal funds; the revenues from this limited number of surgeries represent an immaterial percentage of VUMC's net operating revenue.

VUMC approaches its responsibility to care for patients by following the most widely recognized national and international standards of care, while at all times doing so in accordance with state and federal laws. Our clinical teams provide transgender care that is informed by the professional practice standards and guidance established by leading medical specialty societies, such as the Endocrine Society and the World Professional Association of Transgender Health (WPATH). We fully comply with the requirements of legislation passed by the General Assembly in 2021, now codified at Tenn. Code Ann. §63-1-169, which prohibits providing hormone therapy to prepuberal children.

VUMC serves as the employment home for over 40,000 people and our people express their views in many forums, including hundreds of open conferences on our campus facilities each year. Comments from videos posted on social media that are obtained at these kinds of events should not be construed as statements of VUMC policy. VUMC's policies and practices allow employees to request an accommodation to be excused from participating in surgeries or procedures they believe are morally objectionable. We do not condone discrimination against employees who choose to request accommodations.

You have asked that VUMC halt permanent gender affirmation surgeries being performed on minor children. On September 6, 2022, WPATH published a new version of its recommendations to health care professionals for treatment of transgender persons, known as SOC-8. In light of these new recommendations, and as part of completing our internal clinical review of the SOC-8 guidance in patients under 18, we will be seeking advice from local and national clinical experts. We are pausing gender affirmation surgeries on patients under age 18 while we complete this review, which may take several months.

In addition, we understand this issue is likely to be taken up by the General Assembly in its next legislative session. As always, we will assure that VUMC's programs comply with any new requirements which may be established as a part of Tennessee law.

1161 21st Avenue South
D3300 Medical Center North
Nashville, TN 37232-2104

tel 615.343.9324
fax 615.343.7286
wright.pinson@vumc.org

I trust this letter has been responsive to the concerns which have been surfaced to you and your colleagues.

Sincerely yours,

C Wright Pinson

C. Wright Pinson, MBA, MD
Deputy CEO and Chief Health System Officer